EDITOR'S CHOICE

Medical leadership: why it's important, what is required, and how we develop it

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Received 8 November 2009
Accepted 17 August 2010
Published Online First
10 October 2010

ABSTRACT

Good medical leadership is vital in delivering high-quality healthcare, and yet medical career progression has traditionally seen leadership lack credence in comparison with technical and academic ability. Individual standards have varied, leading to variations in the quality of medical leadership between different organisations and, on occasions, catastrophic lapses in the standard of care provided to patients. These high-profile events, plus increasing evidence linking clinical leadership to performance of units, has led recently to more focus on leadership development for all doctors, starting earlier and continuing throughout their careers. There is also an increased drive to see doctors take on more significant leadership roles throughout the healthcare system. The achievement of these aims will require doctors to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which 21st century healthcare is delivered. Developing these attributes will require dedicated resources and the sophisticated application of a variety of different learning methodologies such as mentoring, coaching, action learning and networking.

MEDICAL LEADERSHIP IN THE NHS

It is indisputable that to deliver high-quality care consistently to patients requires, among many other factors, good medical leadership. However, within the UK, leadership skills have traditionally not been prominent in either the curricula or the appraisal and assessment systems of medical students and doctors. When present, leadership as a subject has often been expressed within other areas, such as 'professionalism' or 'communication skills', and attempts to develop and assess leadership have been inconsistent and without a framework.[1] Furthermore, medical career progression has traditionally been based on technical and academic ability at the expense of the so-called 'softer' attributes that contribute to good leadership, such as strong emotional intelligence. This lack of focus and emphasis has led to significant variation in the standards of medical leadership at the top of, throughout and between different NHS organisations and has impacted on the standard of care provided to patients; the enquiries and resulting reports into clinical negligence at Bristol, Alder Hey and Maidstone and Tunbridge Wells Trusts all highlighted organisational deficiencies in medical leadership.[2–4]

Attempts to improve this situation by increasing medical engagement and leadership are sadly not new; the Griffiths report in 1983 sought for doctors to play a significant role in general management, particularly at unit level (leading in many places to the creation of Clinical Directorates),[5] and the 1986 NHS Management Board's 'Resource Management Initiative' was predicated on the full involvement of doctors to improve patient care through better utilisation of hospital resources.[6] In the 1990s, different authors argued for improved doctor leadership and increased medical involvement in the delivery of healthcare,[7–10] and, in 2005, the Royal College of Physicians report 'Doctors in Society' stated that 'the complementary skills of leadership and 'followership' need to be incorporated into doctors' training to support professionalism'.[11] In the last 3 years, Lord Darzi's reviews on the future of healthcare within London[12] and subsequently throughout England[13] highlighted clinical leadership as an essential component of quality care and emphasised this by creating an NHS National Leadership Council to oversee leadership and its development throughout the system.

Encouragingly, despite this significant journey, it would appear that the current focus and set of initiatives on medical leadership and engagement are achieving more impact and at more levels than earlier attempts. One possible reason for this is the Medical Leadership Competency Framework (MLCF), jointly developed by The Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement.[14] The MLCF describes the leadership competencies *all* doctors need to develop and is being incorporated into undergraduate and postgraduate curricula and assessment processes, something not previously attempted. It seeks to ensure that all doctors throughout their careers attain an agreed set of leadership competencies that are essential to being a good doctor; it is predicated on the belief that all medical practitioners should be leading to improve the quality of the service within their speciality, practice or unit. Another possible reason for the increase in the profile of medical leadership lies not in the need for system-wide leadership but in an increasing desire within the system for doctors to aspire to significant positional leadership roles, particularly that of chief executive. A recent report showed that the NHS still lags behind many other developed healthcare systems in this regard, with just 5% of the total chief executive community currently being doctors,[15] compared with around 30% in the USA. Developing a cohort of future medical leaders to accede to these roles requires a different developmental strategy to improving the leadership competencies of all physicians system-wide (and this is discussed in more detail below),

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but is, we would suggest, equally important and more likely to occur if there is earlier awareness and education about leadership in medical curricula as driven by the MLCF. A third reason appears to be demand; junior doctors are becoming increasingly interested in developing these skills for themselves, attracted by the opportunity to affect the environment in which they work and lead improvements in patient care. This rise in interest has driven the emergence of fellowships, courses, schemes and member organisations designed to provide increasing opportunities for medical leadership development.

WHAT LEADERSHIP ATTRIBUTES ARE REQUIRED FROM DOCTORS?

If we are to achieve a position where medical leadership is of a consistently high standard and is embedded throughout the NHS, we need all doctors to be able to take a macroscopic view on healthcare provision and resource allocation and to understand the political, economic, social and technological drivers for change that will influence this view throughout their careers. Doctors, who until now have been taught little of the NHS, will need to learn about the funding, organisation, governance and management that are integral to its workings. They need to be supported by well-developed systems, clear lines of reporting and responsibility, and an organisational culture that provides good information and encourages its use as a vehicle for performance improvement. Finally, all doctors, whether they remain predominantly as medical practitioners, move to lead organisations or take on more strategic roles, need to learn more about 'followership', an increasingly discussed concept that recognises the importance of participation and allowing others to lead. Without doing these things, doctors will remain significantly disadvantaged, unable to participate in discussions regarding service delivery, unable to navigate and lead others through the organisation and system in which they work and on occasions perceived, sometimes rightly, to be barriers to change or toxic influences within their organisations.

For those doctors who aspire to perform more significant positional leadership roles, simply having the knowledge, skills and information described above will not be enough. Future medical leaders will require, and will need to utilise, a broader range of non-technical skills to allow them to lead others, not just within medicine but across all professional boundaries. These skills include creating and communication their vision, setting clear direction, service redesign and healthcare improvement, effective negotiation, awareness of both self and others, working collaboratively and networking. They will need to be able to balance many different competing interests and priorities and manage themselves effectively; to enhance peer credibility, many will seek to continue to deliver high-quality clinical care alongside these prominent leadership positions. They must hold, voice and enact strong personal values and beliefs that impact positively on those around them and place the patient at the centre of decision-making, not the priorities of the provider.

WHAT METHODS ARE AVAILABLE TO DEVELOP MEDICAL LEADERSHIP?

There is considerable debate about whether leaders are born or whether they can be made. While Kotter[16] argues that leadership consists of a series of definable skills that can and should be taught, others have suggested that there must be a prerequisite level of innate natural leadership ability. Regardless of this debate, there is little contention that, while certain individuals and personality types appear to take to leadership roles more readily, all professionals can develop their ability to lead others and can learn some of the techniques and behaviours that are essential for effective leadership at whatever level they work.

The methodologies available and practised for leadership development are vast, ranging from self-directed learning using books and audio recordings, to one-to-one coaching, mentoring, action learning and seminars. In some instances, learning occurs alone and is entirely self-directed, and in others it occurs in teams, or as part of a cohort participating in schemes, fellowships or undertaking formal qualifications.

Schemes and courses

Many doctors at some point in their careers will participate in a medical management and leadership course, typically of a few days duration. Significantly fewer will join a programme, scheme or fellowship to develop their leadership capabilities. Regardless of the exact mechanism of provision, before any individual junior doctor or associated organisation commissions a package of leadership development, they must have clarity on what it is they are seeking to achieve.

For an organisation, it is essential to clarify what the specific aims of any programme or scheme are. Is it to increase the standards of leadership on a system or organisation level, by developing a large cohort of junior doctors through a broad inclusive programme—for example, a scheme for all general practice trainees in a region? Or is it to develop a cohort of high-potential future medical leaders through a more targeted approach involving assessment of potential and competitive recruitment? Proponents of both approaches exist, but in our opinion, neither is 'wrong or right'; they simply address the different strategic challenges of improving the quality of medical leadership throughout the system as opposed to talent spotting and developing high-potential future system-level leaders. However, it is key to making a decision in the knowledge that the choice made will affect the methods that are possible and appropriate for leadership development to occur. For an individual junior doctor, issues of cost, time commitment and provider reputation are important, as are the true learning opportunities and sustainability of any development.

Once participants on any given programme, scheme or course have been confirmed, regardless of selection method, we advocate that each individual's learning needs is assessed. This allows those providing leadership development to tailor their approach, enhances the self-awareness of the participant, and can allow individuals to monitor their own progress. A range of diagnostic tools are available to help individuals to self-assess their leadership skills, and superiors, colleagues and reports can also be involved in any assessment by utilising a 360° appraisal mechanism. Individual participants can be encouraged to express their own personal aims and expectations and these can then be aligned alongside the sponsor organisation's strategy, culture and human resources management.[17]

Leadership schemes and courses definitely have a part to play in developing leadership skills in junior doctors. We believe them to be especially beneficial if the participating individual or team uses 'real-time' challenges facing them and/or their organisation as case study material to be explored within some of the sessions. Further gain is made when programmes are relatively lengthy in duration, allowing learning to be interspersed with periods of reflection, work experience, career progression and further challenges. However, this tends to increase the cost. Purchasing on an individual basis one of the plethora of two or three day courses available in the marketplace can be interesting and beneficial and can significantly improve the knowledge base

of participants with regard to healthcare systems, processes, structures and governance. However, this 'piecemeal' approach is likely to have a limited effect on leadership behaviour—particularly once back in the organisation—and minimal impact on large-scale service improvement.

The leadership-development methodologies listed below, while only a sample, are the most frequently used within leadership programmes.

Mentoring

Mentoring has been defined as 'off-line help by one person to another in making significant transitions in knowledge, work and thinking'[18] and elsewhere as 'a form of human development where one person invests time, energy and personal know-how in helping another person grow and improve to become the best that he/she can become'.[19]

Mentoring can bring significant benefits to the mentee, the mentor and the organisations they work for, and these benefits have been reported for several decades in the management and business press.[20–22] Mentoring has been used in both private and, more recently, public sectors to support the development of people throughout their careers and ensure that organisations are developing future leaders. Most of the research into mentor–mentee relationships has examined the benefits of mentoring to the mentee, finding that mentoring is related to important career outcomes, such as job satisfaction,[23 24] and thus many corporate organisations have encouraged mentoring relationships between organisational members.[25] Less work has been done evaluating the beneficial effects for the mentor, and for the organisations supporting these relationships probably due in part to the complexity of assessing and defining both what is or is not a mentoring relationship and what may be appropriate outcomes.

The medical literature on mentoring remains relatively sparse, but anecdotally, mentoring within medicine has traditionally been an informal process, occurring spontaneously between junior doctors and their seniors. These uni-professional arrangements tend to be associated with a high level of satisfaction, as they are often based on mutual respect and admiration. However, increased clinical, research and administrative demands and the modernisation of medical career pathways have eroded somewhat the opportunities for these traditional mentoring–mentee relationships to be established,[26] and where they are, they are not without disadvantage; mentors are often inextricably linked to the appraisal, assessment and future prospects of the mentee, may have competing interests and agendas, and potentially impose their viewpoints on workplace issues and culture. Furthermore, traditional medical mentoring has tended to centre on clinical skill development—only a portion of the abilities desirable in a senior doctor—and has on occasions been inaccessible to minority groups, such as women or black and minority ethnic trainees. These factors mean that, if mentoring is to be used as a leadership developmental tool for doctors, we must be aware of its potential limitations and consider undertaking a more formalised process to establish mentor–mentee pairings.[27]

We have been in a mentee–mentor relationship for 2 years now, and have found it mutually beneficial, stimulating and rewarding. Subjects that we have frequently discussed in mentoring sessions are detailed in box 1. We strongly advocate that any aspiring medical leader should seek to establish a mentoring relationship to help personal and professional development. What form this might take and with whom is very much down to the individual concerned. One might opt to identify potential mentors through senior colleagues, formal schemes or by approaching senior leaders in the organisations in which one works. The mentor may be of the same professional background or from a different one, but should have some experience in developing others and be truly interested in investing the time and energy required to mentor someone. Individuals attempting to create new mentoring relationships should not be disheartened if initial attempts do not meet with immediate success; establishing productive mentoring relationships is not easy and even schemes utilising formalised matching of mentors and mentees meet with variable success.[28]

Box 1 Potential topics for discussion between mentors and mentees

- Career aspirations and career planning over the short, medium and long term
- Management of difficulties within professional and personal relationships
- Delivery of previously agreed goals
- Project management and leadership challenges currently facing the mentee
- The impact and management of political factors in delivering healthcare
- Personal life issues and events

In our experience, we have witnessed clear benefits in the mentoring of junior doctors by senior non-medical leaders (or where medical, now occupying a predominantly managerial role). It can be enlightening for both participants, providing a view into each other's world and bringing a very different perspective to issues. Furthermore, it allows truly 'off-line' support and advice; mentees are able to discuss fears, doubts or concerns regarding their career paths without fear of appearing uncommitted to their current route, something many participants have made clear cannot happen with supervising consultants or GP partners.[29] Finally, opportunities may be provided that otherwise would not be open to someone working at a more junior level, including attendance at meetings, advisory roles, invitations to address key audiences, and opportunities to influence the decision-making process.

Once a mentoring relationship is established, it is important to regularly consider the ongoing benefits of continuing to meet, the stage at which the relationship is at, and whether it remains useful for both involved. A 'no-fault' divorce clause set up at the start of any relationship is commendable as it facilitates a trouble free exit from the relationship at any point at which either party no longer feels willing or able to participate.

Coaching

Coaching, especially for senior leaders, has been expanding over the last few years. Coaching is aimed at performance enhancement in a specific area—that is, it is goal orientated and thus tends to be a relatively short-term process. The goals are usually set in conjunction with the coach, and the coach has predominant ownership of the process. There is still insufficient research looking at what happens in the coaching process that can support leadership development, when it is successful, why it is successful in some settings, and what sort of leaders benefit most from coaching. Both of us have received coaching, and found it useful, although benefits vary according to professional circumstance and the relationship formed with the coach in question. Junior doctors have little opportunity to access this

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leadership development resource (which may in part be due to the significant cost per person involved), although more organisations are offering coaching for more senior doctors when appointed to new leadership roles, such as clinical or medical director. Coaching is also incorporated into certain UK schemes for junior doctors, such as NHS London's Darzi fellowships.[30]

Action learning

Action learning is based on the notion that leadership knowledge, skills and attitudes can be developed through the joint problem solving of issues that arise in the work place, during real life projects, and by observing and working with others. Not only can learning occur, but the individual whose issues are being focused on can, by working through them in a safe, supportive and facilitated environment, gain valuable insight and reassurance and formulate plans to take the issues forward. Typically, an action learning 'set' consists of six to eight individuals with a common purpose or interest—be that their workplace, sponsor organisation or beliefs—accompanied by an experienced facilitator. Participants will request time slots to air the issue they feel they wish to work through and address, and then, through any mixture of open questions, appreciative enquiry, role play and alternative perspectives, seek to address it. The aim is not to give advice, as tempting as this can be at times, but to help and empower the individual in question to reach their own conclusions. Reflection by all involved can often help members of the group learn from others' problems and challenges, particularly where individuals are working on similar improvement or change projects within similar environments.

Networking

Networking can play an important part in leadership development, and, when successful, networks may be sustained over a longer period than coaching or even mentoring. Networking is difficult to define but tends to involve the creation of interdependent, often mutually beneficial, relationships. It can occur formally—for example, by participating in national groups or being an active member of a society—or informally, by getting to know, interact with and then work with others who share a common purpose or interest in similar issues.

The impact of networking can be very powerful, but the creation of networks requires not only a significant conscious effort by the individual, but support and help from the organisation or group with whom they work. We have witnessed networking occurring in two distinct ways within the leadership-development schemes in which we have delivered or participated.

Peer networking

Expressing an interest in leadership positions and developing one's leadership abilities can bring with it some risk. Nowhere has this been more true than in medical leadership, where claims of 'going over to the dark side', although diminishing, are still familiar refrains. This can lead to a sense of isolation. Establishing a network of like-minded individuals, who can support, encourage and provide opportunities for each other not only to learn and develop but also to take on new roles or leadership positions, can have pronounced effects, diminishing the sense of isolation and making individuals feel like they are part of a team or movement. Combining people's expertise and energy can result in achieving projects that would have previously felt unattainable to individual participants.

Networking with senior leaders

Networking with senior leaders can provide opportunities to experience and witness interactions and events to which individuals may not normally be privy. Senior leaders often provide a wide range of contacts, and thus further networks, and offer a more diverse range of perspectives, views and information. Networking and learning with them allows individuals to increase their own profile, that of their organisation and of their staff and colleagues. This may bring further opportunities to contribute and be involved in key decision-making. Furthermore, it is prudent for any future medical leader to establish a network of supporters and senior leaders around them, rather than rely on the patronage of a single mentor or senior sponsor for two reasons: firstly, relationships change, and over-reliance on any single individual can create dependency and subservience; secondly, for those who aspire to lead in different organisations and regions and at

Key learning points

- Medical leadership is vitally important to delivering high-quality care to patients.
- Medical leadership skills have traditionally been given less credence than technical or academic ability, though there are signs that this is changing.
- Doctors must develop a wide range of leadership knowledge, skills and behaviours during their training if they are to be effective practitioners and leaders within their organisations. Vitally this includes 'followership'.
- Courses, programmes and schemes can use a variety of methods to develop medical leaders, including mentoring, coaching, networking and action learning.
- Leadership training is most beneficial to individual and organisation if this development occurs alongside 'real-time' experiential learning, where trainees can experience the challenge of leading projects not intricately linked to their day-to-day clinical work.

Key references

- The NHS National Leadership Council (http://www.nhsleadership.org.uk/), where you can access links to opportunities in different regions, the first annual report of the NLC, and more information on Clinical Leadership Fellowships.
- The NHS Institute for Innovation and Improvement (http://www.institute.nhs.uk/) and The Academy of Medical Royal Colleges (http://www.aomrc.org.uk/), where you can access the Enhancing Engagement in Medical Leadership project, Medical Leadership Competency Framework and the Medical Chief Executives in the NHS study.
- The Department of Health (http://www.dh.gov.uk) to access publications such as 'High Quality Care for All', the report of the Next Stage Review.
- **Clutterbuck D**. *Everyone Needs a Mentor—Fostering Talent in your Organisation*. Fourth edition. London: CIPD, 2004. An excellent text exploring the importance and types of mentoring used to develop people.
- **Sambunjak D**, Straus SE, Marusic A. Mentoring in academic medicine: a systematic review. *JAMA* 2006;**296**:1103—15. A thorough recording and evaluation of the available literature evaluating the impact of mentoring in academic medicine, from three authors who have published widely on the topic.

different levels of healthcare (local, regional, national and international), it is unlikely that any single individual can provide the opportunities and experiences required to progress.

Experiential learning

If real learning about leadership and the management of others is to occur, at least some of it should be experiential. Real challenge in the form of 'stretch assignments' can offer important developmental opportunities, requiring the individual to work outside their comfort zone and learn new skills to achieve the desired results. Experiential learning can take many forms, including entirely new jobs, secondments to other organisations, or part-time roles alongside ongoing clinical work. In the case of junior doctors, the newly formed Medical Leadership Fellowships, funded centrally but delivered by the Strategic Health Authorities, typically last 1 year and require participants to take an 'Out of Programme Experience' to work within trusts on quality improvement projects and service redesign. The Chief Medical Officer's Clinical Advisor Scheme, run from the Department of Health but involving other partner organisations including the WHO, BUPA and the National Patient Safety Agency, provide another opportunity for junior doctors to take time away from clinical work and experience some public health, medical management and patient safety challenges. However, not all stretch assignments require stepping out of clinical work; much can be learnt by balancing clinical work alongside contributing to other projects or working part time in another capacity.

SUMMARY

Good medical leadership is becoming increasingly vital to the provision of high-quality healthcare. Leadership development should be an essential component of the education of all medical staff. Doctors must not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments. This will not occur by accident, but must be the responsibility of every individual doctor, the organisation they work in, and the system as a whole. Different leadership methodologies are available to do this, and each individual will find some more pertinent to them than others, but mentoring relationships, strong professional networks and experiential learning are all excellent ways for future medical leaders to start developing the requisite skills and experience.

MULTIPLE-CHOICE QUESTIONS (TRUE (T)/FALSE (F); ANSWERS AFTER THE REFERENCES)

1. The following organisations were responsible for the development of the Medical Leadership Competency Framework:

A. British Medical Association
B. British Association of Medical Managers
C. The Academy of Medical Royal Colleges
D. The National Association of Primary Care
E. The NHS Institute for Innovation and Improvement

2. The Medical Leadership Competency Framework:

A. Describes a range of leadership competencies integral to medical practice
B. Is predicated on the belief that all medical practitioners should be leading to improve the quality of healthcare
C. Is now fully embedded in all postgraduate curricula
D. Pertains only to the assessment and appraisal of junior doctors
E. Contains five domains, all of which contain four further elements

3. Mentoring:

A. Is only really beneficial for the mentee
B. In medicine is traditionally an informal process occurring between doctors in similar specialities
C. When not formalised may be difficult for women and black and minority ethnic groups to access
D. Is most effective when the mentor is directly responsible for the assessment, appraisal and career progression of the mentee
E. Is thought to have little or no influence on career outcomes and job satisfaction in areas outside of medicine

4. When developing leadership and management skills in doctors:

A. Short courses away from the workplace may improve knowledge base but often do not allow enough time for reflection, work-based development and significant improvements in leadership skills
B. Coaching is a relatively inexpensive option
C. It is best that learning and development occur in isolation from other members of the healthcare team
D. Action learning sets require experienced and sophisticated facilitation
E. The individual or organisation commissioning a development package must be clear exactly what they are seeking to achieve in doing so

5. Doctors interested in leadership and management:

A. Should consider networking as a powerful way to access opportunities and to gain influence
B. Need not network with senior colleagues if they have one significant sponsor or mentor
C. May find peer-to-peer networking a valuable source of support and reassurance if lacking within their normal peer group or organisation
D. Can acquire important skills by undertaking 'stretch assignments', fellowships and new role
E. Can raise their profile by being embedded in both formal and informal networks

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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ANSWERS

1. A (F); B (F); C (T); D (F); E (T)
2. A (T); B (T); C (F); D (F); E (T)
3. A (F); B (T); C (T); D (F); E (F)
4. A (T); B (F); C (F); D (T); E (T)
5. A (T); B (F); C (T); D (T); E (T)

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General Medical Council

Professional standards

In effect: 12 March 2012

Leadership and management



Summary

This guidance explores your role in management and leadership. It covers your responsibilities relating to

- employment issues
- teaching and training
- planning, using and managing resources
- helping to develop and improve services.

Following this guidance will help you work better with your colleagues and help to improve the service you provide to your patients. helping to develop and improve services.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Leadership and management

Professional standards: More detailed guidance

This guidance came into effect 12 March 2012.

This guidance was last updated on 13 December 2024.

You can find the latest version of all our professional standards at www.gmc-uk.org/guidance.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

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About our Leadership and management guidance

Being a good medical professional means more than simply being a good clinician. In their day-to-day role all members of the healthcare team can provide leadership to their colleagues and vision for the organisations in which they work and for their profession as a whole. However, unless medical professionals are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer.

This guidance, which forms part of the professional standards, sets out the wider management and leadership responsibilities of doctors, physician associates and anaesthesia associates (collectively referred to as 'medical professionals') in the workplace, including:

- responsibilities relating to employment issues
- teaching and training
- planning, using and managing resources
- raising and acting on concerns
- helping to develop and improve services.

The principles in this guidance apply to all medical professionals whether they work directly with patients or have a formal management role.[1]

The standards of good practice apply to doctors, physician associates and anaesthesia associates (collectively referred to as medical professionals and whom we address directly as 'you' throughout the guidance). As with all our professional standards, this guidance applies to all our registrants to the extent it is relevant to the individual's practice.

How these principles will apply in practical terms depends on an individual's role and responsibility. For example, how a professional working under supervision will show leadership or take responsibility for managing resources will be different from a professional working in a more autonomous or senior role.

You continue to have responsibility for the safety and wellbeing of patients when you perform non-clinical duties, including when you work as a manager. You are still accountable to the General Medical Council (GMC) for your decisions and actions, even if someone without medical training could perform your role.

This guidance applies across the UK and should be interpreted in the context of the relevant national and local arrangements for the delivery of health services. It sets out:

- the duties and principles that apply to all medical professionals
- the extra responsibilities that may only apply to some medical professionals (for example, those with management or leadership responsibilities at a personal, team, organisation or policy level). This may include formal management roles, such as clinical or medical directors, or roles with responsibility for supervising and managing staff, resources and services.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

How this guidance applies to you

In this guidance, the terms 'you must' and 'you should' are used in the following ways.

- 'You must' is used for a legal or ethical duty you're expected to meet (or be able to justify why you didn't).
- 'You should' is used for duties or principles that either:
  - may not apply to you or to the situation you're currently in, or
  - you may not be able to comply with because of factors outside your control

The professional standards describe good practice, and not every departure from them will be considered serious. You must use your professional judgement to apply the standards to your day-to-day practice. If you do this, act in good faith and in the interests of patients, you will be able to explain and justify your decisions and actions. We say more about professional judgement, and how the professional standards relate to our fitness to practise processes, appraisal and revalidation, at the beginning of *Good medical practice*.

Duties of a medical professional in the workplace

1. Medical professionals make an important contribution to the management and leadership of health services and the delivery of healthcare across the UK as part of a multidisciplinary team. All medical professionals have some responsibilities for using resources; many will also lead teams or be involved in supervising colleagues.

2. The primary duty of all medical professionals is for the care and safety of patients. Whatever your role, you must do the following.

   a. Engage with colleagues[2] to maintain and improve the safety and quality of patient care.

   b. Contribute to discussions and decisions about improving the quality of services and outcomes.

   c. Raise and act on concerns about patient safety.

   d. Demonstrate effective team working and leadership.

   e. Promote a working environment free from unfair discrimination, bullying and harassment, bearing in mind that colleagues and patients come from diverse backgrounds.

   f. Contribute to teaching and training doctors, physician associates, anaesthesia associates and other healthcare professionals, including by acting as a positive role model.

   g. Use resources efficiently for the benefit of patients and the public.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Working with colleagues

Leadership

All medical professionals

3. Most medical professionals work in multidisciplinary teams. The work of these teams is primarily focused on the needs and safety of patients. The formal leader of the team is accountable for the performance of the team, but the responsibility for identifying problems, solving them and taking the appropriate action is shared by the team as a whole.

4. You must be willing to work with other people and teams to maintain and improve performance and change systems where this is necessary for the benefit of patients.

5. You should respect the leadership and management roles of other team members, including non-medical colleagues.

Respect for colleagues

All medical professionals

6. It is essential for good and safe patient care that medical professionals work effectively with colleagues from other health and social care disciplines, both within and between teams and organisations. Whatever the composition of the teams you work in, you must respect and value each person's skills and contribution.

7. You must tackle discrimination where it arises and encourage your colleagues to do the same. You must treat your colleagues fairly and with respect. You must not bully or harass them or unfairly discriminate against them. You should challenge the behaviour of colleagues who do not meet this standard.

8. You must follow and keep up to date with your organisation's policies about employment, equality and diversity. You must get advice on these issues if you need it.

Medical professionals with extra responsibilities

9. You must actively advance equality and diversity by creating or maintaining a positive working environment free from discrimination, bullying and harassment. You must make sure that your organisation’s policies on employment and equality and diversity are up to date and reflect the law.[3]

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Communication within and between teams

10. Multidisciplinary teams can bring benefits to patient care when communication is timely and relevant, but problems can arise when communication is poor or responsibilities are unclear.

All medical professionals

11. You must make sure that you communicate relevant information clearly to:

a. colleagues in your team

b. colleagues in other services with which you work

c. patients and those close to them in a way that they can understand, including who to contact if they have questions or concerns. This is particularly important when patient care is shared between teams.

12. You should not assume that someone else in the team will pass on information needed for patient care. You should check if you are unclear about the responsibility for communicating information, including during handover, to members of the healthcare team, other services involved in providing care and patients and those close to them.

13. You should encourage team members to cooperate and communicate effectively with each other and other teams or colleagues with whom they work. If you identify problems arising from poor communication or unclear responsibilities within or between teams, you should take action to deal with them.

Medical professionals with extra responsibilities

14. You must provide necessary and timely information to those you manage so they can carry out their roles effectively. You should also pass on any relevant information to senior managers and make sure that arrangements are in place for relevant information to be passed on to the team promptly.

15. You must be satisfied that systems are in place to communicate information about patient care.

Responsibility and accountability

16. Whether you have a management role or not, your primary duty is to patients. Their care, dignity and safety must be your first concern. You also have a duty to the health of the wider community, your profession, your colleagues and the organisation in which you work.

All medical professionals

17. You should establish clearly with your employer the scope of your role and the responsibilities it involves, including non-clinical responsibilities. You should raise any issues

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

of ambiguity or uncertainty about responsibilities, including in multidisciplinary or multi-agency teams, to clarify:

a. supervision arrangements for staff and lines of accountability for the care provided to individual patients (for more information on supervision see paragraphs 60 - 62 of this guidance)

b. who should take on leadership roles or line-management responsibilities

c. where responsibility lies for the quality and standard of care provided by the team.

Medical professionals with extra responsibilities

18. If you are responsible for leading or managing a team, you must make sure that staff are clear about:

a. their individual and team roles and objectives

b. their personal and collective responsibilities for patient and public safety

c. their personal and collective responsibilities for honestly recording and discussing problems.

19. You should:

a. contribute to setting up and maintaining systems to identify and manage risks in the team's area of responsibility

b. make sure that all team members have an opportunity to contribute to discussions

c. make sure that team members understand the decisions taken and the process for putting them into practice

d. make sure that each patient's care is properly coordinated and managed.

20. You are accountable to the GMC for your own conduct and any medical advice you give. This includes while you serve as a member of a decision-making body for a health or social care organisation, such as a hospital or health board.

21. If, as a member of a board or similar body, you are concerned that a decision would put patients or the health of the wider community at risk of serious harm, you should raise the matter promptly with the chair. You must also ask for your objections to be formally recorded and you should consider taking further action in line with our guidance in *Raising and acting on concerns about patient safety* [4]

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Maintaining and improving standards of care

Reflecting on your practice

All medical professionals

22. You should regularly reflect on your own performance, your professional values and your contribution to any teams in which you work. You should ask for, and be prepared to act on, feedback from colleagues and patients, including through the outcomes of audits, appraisals and performance reviews (see paragraphs 30 - 32), and through patient complaints and comments.

Medical professionals with extra responsibilities

23. Leading by example, you should promote and encourage a culture that allows all staff to contribute and give constructive feedback on individual and team performance. You should make sure that systems are in place to achieve this.

Ensuring high standards of care

24. Early identification of problems or issues with the performance of individuals, teams or services is essential to help protect patients.

All medical professionals

25. You must take part in regular reviews and audits of the standards and performance of any team you work in, taking steps to resolve any problems.

26. You should be familiar with, and use, the clinical governance and risk management structures and processes within the organisations you work for or to which you are contracted. You must also follow the procedure where you work for reporting adverse incidents and near misses. This is because routinely identifying adverse incidents or near misses at an early stage, can allow issues to be tackled, problems to be put right and lessons to be learnt.

27. You must follow the guidance in *Good medical practice* [5] and *Raising and acting on concerns about patient safety* [4] when you have reason to believe that systems, policies, procedures or colleagues are, or may be, placing patients at risk of harm.

Medical professionals with extra responsibilities

28. If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

patient feedback. You must make sure that any such failure is dealt with quickly and effectively.

29. If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking, are in place to monitor, review and improve the quality of the team's work. You must work with others to collect and share information on patient experience and outcomes. You must make sure that teams you manage are appropriately supported and developed and are clear about their objectives.

Performance review and revalidation

All medical professionals

30. You should be familiar with the individual performance review process in all the organisations in which you work.

31. You must take part in annual appraisals and you must make sure that your appraisal covers your whole practice, including any non-clinical roles.

32. If you hold a licence to practise, you must take part in revalidation.

Medical professionals with extra responsibilities

33. You must make sure that staff you manage, including colleagues in sessional and other non-training posts, have enough time to prepare for their appraisals or performance reviews and that they have the opportunity to complete them fully and on time.

34. You must be honest and objective and keep to the principles of equality and diversity when appraising or assessing colleagues' performance. This includes when assessing trainees during the Annual Review of Competence Progression (ARCP) or other equivalent process. The safety of patients and the public could be put at risk if you make false, exaggerated or incomplete comments about another professional's competence or experience.

35. You should support staff you manage to complete learning and development activities identified by appraisals or performance reviews.

36. If you appraise or assess colleagues, you should make sure that you have the appropriate knowledge and skills. You should make sure that any staff you manage who also carry out appraisals have the knowledge and skills to do so, and are given regular feedback on how they perform this role.

37. If you are responsible for designing and delivering services, you should make sure that there is an appropriate appraisal or performance review process in place and that staff understand and follow it. You should also make sure that there are ways of dealing with any problems that appraisals bring to light. If the appraisal process includes clinical academic staff, you should make sure it follows the Follett principles.[6]

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

38. If you are a responsible officer within a designated body, you will have extra responsibilities as set out in the relevant regulations[7] and you must take account of any guidance produced by the departments of health[8] or your organisation.

Keeping up to date

All medical professionals

39. You must keep your skills and knowledge up to date in all areas of your work, whether in a clinical or non-clinical setting.

40. You must keep up to date with, and follow, the laws and statutory codes of practice relevant to your particular responsibilities and location[9] and you should get expert advice when you need it. You must be familiar with the relevant guidelines and developments that affect your work and use them to help you with your practice.

Information governance

41. Medical professionals need accurate, up-to-date and accessible information to deliver good and safe care to patients. Patients need to understand how information about them will be collected, stored and used and how their confidentiality and privacy will be protected. Good information governance systems can help to achieve this and contribute to providing high quality and safe care. They can also provide valuable information to allow teams and services to improve the quality and safety of care they deliver. All medical professionals have a role to play in contributing to these systems.

All medical professionals

42. You must keep accurate and clear patient records following the advice in *Good medical practice*.[5] You should make sure that non-clinical records you keep, including financial records, are clear, accurate and up to date.

43. You must follow the guidance in *Confidentiality: good practice in handling patient information* on protecting information and disclosing information for patient care or secondary purposes.[10]

44. You should be familiar with, and follow, the confidentiality, data protection and record management policies and procedures where you work and know where to get advice on these issues.

Medical professionals with extra responsibilities

45. If you are responsible for managing patient records or other patient information, you must follow the specific guidance for managers on protecting information set out in *Confidentiality:*

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

good practice in handling patient information.[11]

46. You must make sure that any other records you are responsible for, including financial, management or human resources records, or records relating to complaints, are kept securely and are clear, accurate and up to date.

47. You must make sure that records you are responsible for are made, stored, transferred and disposed of in line with the data protection law and other relevant legislation.

Employment

48. If you are involved in any aspects of employing staff such as recruiting, promoting or rewarding staff, including sitting on appointment or reward committees, you must work within your professional values and your organisation's policies and procedures, and observe the principles of fairness, equality and diversity.

Recruitment, rewards and compensation

All medical professionals

49. When applying for posts, you must always be open and honest about your experience, qualifications and current employment status.

50. When applying for and accepting posts, you must follow the guidance in *Good medical practice* [5], bearing in mind how your decisions may affect patient safety.

Medical professionals with extra responsibilities

51. If you have specific responsibility for recruitment, promotion or other staff rewards or compensation, you must make sure that the process is fair and transparent, and that decisions are based on objective criteria.

52. You must make sure you have, and anyone you appoint to take part in these activities has, the skills and competence needed and the opportunity to undertake appropriate training, including in relation to equality, diversity and non-discrimination in employment matters.

Induction and mentoring

53. Understanding the systems in place and how an organisation operates helps to make sure that medical professionals can deliver safe, effective and efficient care to patients as soon as they start a new job. Induction and mentoring schemes and access to other support mechanisms are important ways of achieving this. While important for all medical professionals, this may be particularly important for those who are new to clinical practice, have trained outside the UK[12] or are taking on a role in a new area or at a higher level.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Induction

***All* medical professionals**

54. You must take part in the induction offered by your employer when you join an organisation or move into a new role. You should also contribute to the induction of colleagues when asked.

Medical professionals with extra responsibilities

55. You must make sure that any new healthcare professional you manage is offered relevant induction and that induction policies and procedures contain information that is relevant, accessible and proportionate to their role and length of employment within your organisation.

Mentoring

All medical professionals

56. You should be willing to take part in a mentoring scheme offered by your employer.

Medical professionals with extra responsibilities

57. You should be willing to take on a mentoring role for more junior colleagues and other healthcare professionals.

58. If you have agreed to act as a mentor, you must make sure that you are competent to take on the role and that you can fulfil your responsibilities, including undertaking appropriate training and keeping your skills up to date. You must be clear about the aims and purpose of the mentoring, the scope of your role as a mentor and your availability to provide advice and support when needed.

59. You must make sure that staff who are new to an organisation or are moving into a new role have access to an appropriate mentoring arrangement[13] , where relevant, depending on the nature of their clinical practice and their responsibilities.[13]

Supervision

All medical professionals

60. You must recognise and work within the limits of your competence and you must make sure, to the best of your ability, that you are appropriately supervised for any task you perform. You must be willing to ask for advice and support from colleagues when necessary.

Medical professionals with extra responsibilities

61. You must make sure that the people you manage have appropriate supervision, whether

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

through close personal supervision (for newly qualified colleagues, or colleagues in training, for example) or through a managed system with clear reporting structures.

62. If you are responsible for supervising staff, whatever your role, you must understand the extent of your supervisory responsibilities, give clear instructions about what is expected and be available to answer questions or provide help when needed. You must support any colleagues you supervise or manage to develop their roles and responsibilities by appropriately delegating tasks and responsibilities. You must be satisfied that the staff you supervise have the necessary knowledge, skills and training to carry out their roles.

Teaching and training

All medical professionals

63. Many of the skills of being a medical professional can be learnt only by specific, on the job training in the work placements begun prior to qualification and continuing through the early post-qualification years. Every medical professional who comes into contact with students or healthcare professionals in training should act as a positive role model in their behaviour towards patients, colleagues and others.

64. If you are formally involved in teaching in the workplace - for example, teaching trainee doctors, physician associates or anaesthesia associates on placements - you must develop the skills, attitudes and practices of a competent teacher. This includes respecting cultural diversity and making reasonable adjustments for those with a disability without affecting patient safety or educational outcomes.

Medical professionals with extra responsibilities

65. If you are responsible for managing teaching and training in your organisation, you must make sure:

a. Only people with the appropriate knowledge, skills and attitudes carry out any teaching and training for which you are responsible.

b. There are enough staff members from appropriate disciplines, and with the necessary skills and experience[14], to deliver teaching and training and to support the learning and development of trainees and students.

c. Systems are in place to identify and record the educational and training needs of students, trainees and staff, including locums, so that the best use is made of the time and resources available for keeping knowledge and skills up to date.

d. An appropriate environment for training is provided, including by implementing reasonable adjustments to meet individual trainees' needs in line with the *Equality Act 2010*.[15]

e. You provide opportunities for those you manage to keep up to date and develop their

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

skills as teachers and trainers, and make sure that there are systems in place for regular feedback and appraisal of those skills.

Grievance, performance and health

Grievance

All medical professionals

66. You should understand the difference between a personal grievance, that is a complaint about your own employment situation, and a concern about a risk, malpractice or wrongdoing that affects others. This is particularly important if patients or members of the public are at risk of harm[16]. It can sometimes be difficult to separate personal grievances from a concern about patient safety. If these overlap, you should acknowledge any personal grievance that may arise from the situation, but focus on patient safety.[17] You should as far as possible make sure you use the correct procedure to make your personal grievance known or raise your concern.[18]

67. If you have a personal grievance that you cannot resolve informally, you should follow your organisations grievance procedure. If you have a concern about patient safety, you must follow the guidance in *Raising and acting on concerns about patient safety* [4]

Medical professionals with extra responsibilities

68. You should help staff you manage to identify the appropriate procedure for dealing with their personal grievance or concern about patient safety.

Performance and health

All medical professionals

69. You must make sure that your own health does not put patients at risk and you must follow the guidance in *Good medical practice* [5] in relation to your own health.

70. You should be aware that poorly performing colleagues may have health problems and respond constructively where this is the case. You should encourage such colleagues to seek and follow professional advice and offer them appropriate help and support. You must not unfairly discriminate against colleagues because of an issue related to their health or a disability.

71. You should, as far as possible, support colleagues who are experiencing performance problems.

72. But, in all cases, you should remember your duty to raise concerns where you believe a colleague may not be fit to practise or may otherwise pose a risk of serious harm to patients.[4]

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Medical professionals with extra responsibilities

73. You must promote the health and wellbeing of staff you manage.

74. You must make sure that there are clear and effective procedures for responding to concerns about colleagues' conduct, performance or health. This includes referring them to occupational health or other services, where appropriate, and making sure that staff are aware of these procedures.

75. You should be prepared to discuss constructively and sympathetically any work problems that the people you manage may have. You must deal supportively and, where possible, openly with problems in the conduct, performance or health of people you manage.[19]

76. You must make sure that people you manage have access to support for any health or performance problems they have. You must make sure that people are not unfairly discriminated against because of their health or disability.

77. You must make sure that you respond appropriately to requests for reasonable adjustments for staff with a disability or health condition in line with the Equality Act 2010.

Writing references

78. If you have been asked to or have agreed to write a reference for a colleague, you must follow the guidance in paragraph 62 of *Good medical practice*.[20]

Planning, using and managing resources

All medical professionals

79. Whatever your role or level in your organisation, whether you are a, junior, non-training grade or other doctor, physician associate or anaesthesia associate ,you should be willing to demonstrate leadership in managing and using resources effectively. This means that you should be prepared to contribute to discussions and decisions about:

a. allocating resources and setting priorities in any organisation in which you work

b. commissioning services for the wider population of patients.

80. You should have enough understanding of how finances are allocated and managed in the services in which you work to help with your role in committing resources for the benefit of patients.

81. To minimise waste, improve services and promote the effective use of resources, you should take financial responsibility for delivering your service at a level appropriate to your role. You should understand the roles and policies of local and, where relevant, regional and national agencies involved in healthcare if they affect your role as a medical professional.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Medical professionals with extra responsibilities

82. If you are responsible for managing resources, or commissioning or delivering health services, you should have detailed knowledge of how management processes work and how they affect the delivery of patient care.

83. You must make sure that you are competent and have the necessary training or advice for any financial responsibilities that are part of your role. You must make sure that those you manage have the necessary skills and advice to fulfil their roles.

Allocating resources

84. All medical professionals must make the care of patients their first concern. However, the treatment options that can be offered to patients may be affected by limits on resources.

All medical professionals

85. If you make decisions about access to treatments on a case by case basis, without referring to agreed policy or guidelines, you risk introducing elements of unfair discrimination or may fail to consider properly the patient's other legal rights. When making decisions about using resources, you must do the following.

1. Provide the best service possible within the resources available, taking account of your responsibilities towards your patients and the wider population.
2. Be familiar with any local and national policies that set out agreed criteria for access to a particular treatment.[21]
3. Make sure that decisions about setting priorities that affect patients are fair and based on clinical need and the likely effectiveness of treatments, and are not based on factors that may introduce discriminatory access to care.[22]
4. Be open and honest with patients[23] and the rest of the healthcare team about the decision-making process and the criteria for setting priorities in individual cases.

86. You should involve colleagues, including other healthcare professionals, in discussions about how to allocate wider resources. If issues or disputes about allocating resources arise, you should try to sort them out by discussing options with, for example, patients, the healthcare team, other colleagues (including other health and social care professionals) and managers. You should be open and honest with patients when resource constraints may affect the treatment options available.[24]

Medical professionals with extra responsibilities

87. If you have a management role or responsibility, you will often have to make judgements about competing demands on available resources. When making these decisions, you must

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consider your primary duty for the care and safety of patients. You must take account of any local and national policies that set out agreed criteria for access to particular treatments and allocating resources, and make sure that these policies are available to clinical staff.

88. If you are concerned about how management decisions might conflict with your primary duty to patients, you must take steps to manage or deal with any conflict; for example, by:

a. asking for colleagues' advice

b. declaring the conflict to your board or other decision-making body

c. asking for advice from external professional or regulatory bodies, including defence organisations, if necessary.

Honesty, integrity and conflicts of interest

All medical professionals

89. If you have financial or other personal interests in organisations providing health or social care, or in products used in health or social care, you must follow the advice in *Identifying and managing conflicts of interest* [25] and in *Good medical practice* [5]

Medical professionals with extra responsibilities

90. If you are responsible for managing and allocating funds or resources, you must make sure that they are used for the purposes they were intended for and are clearly and properly accounted for. You should also make sure that appropriate professional services, including audits, are commissioned when necessary.

91. You should make sure there are adequate systems in place to monitor financial and management information. You and those you manage should make full use of these systems, including when awarding contracts and managing waiting lists and service plans.

92. You must make sure that there are appropriate systems in place to make sure that actual or perceived conflicts of interests are managed in an open way, and in line with the guidance in *Identifying and managing conflicts of interest* [25] and *Good medical practice.*[5]

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

Endnotes

1. Although these principles are relevant to all medical professionals, whatever roles they have, the judgment in Remedy UK Ltd, R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin) found that there are some roles that are so far removed from practising medicine that the GMC's fitness to practise procedures do not apply to them. However, medical professionals are still accountable to the GMC when they are performing a wide range of clinical management roles (for example, as a clinical or medical director) or other non-clinical roles (for example, as a medical educator or researcher), even if medical knowledge or expertise is not needed for the roles (for example, as a chief executive of a hospital).
2. Those you work with, including managers of services, whatever their role.
3. For example, you must make sure policies accurately reflect employment and related legislation, including the Equality Act 2010. If you are working in Northern Ireland, see The Gaps between GB and NI Equality Law (pdf) (January 2011), which sets out the differences between the legislative framework and protections in Northern Ireland.
4. General Medical Council (2012) *Raising and acting on concerns about patient safety* London, GMC
5. General Medical Council (2024) *Good medical practice* London, GMC.
6. Follett B, Paulson-Ellis M (2001) A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties London, Department for Education and Skills.
7. Medical Profession (Responsible Officers) Regulations 2010 (which cover England, Wales and Scotland) or the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010.
8. Department of Health (England 2010) The Role of the Responsible Officer - Closing the gap in Medical Regulation - Responsible Officer Guidance (pdf), Department of Health. Department of Health, Social Services and Public Safety (2011) Confidence in care: Guidance on the role of responsible officers for doctors and employers (pdf) Belfast, Department of Health, Social Services and Public Safety. At the time of printing, no additional guidance had been published by the departments of health in Scotland and Wales.
9. For example, you must be familiar with the Equality Act 2010, data protection law and relevant employment legislation.
10. General Medical Council (2017) *Confidentiality: good practice in handling patient information* London, GMC.
11. General Medical Council (2017) *Confidentiality: good practice in handling patient information* London, GMC, paragraphs 128 - 130 (Records management and retention).
12. Slowther A et al (2009) Non UK qualified doctors and Good Medical Practice: the experience of working within a different professional framework University of Warwick.

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf

13. The Standing Committee on Postgraduate Medical and Dental Education (1998) Supporting doctors and dentists at work: an inquiry into mentoring London, SCOPME, described mentoring as: 'The process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee.'

14. GP trainers are required to be approved under section 34I(1) of the Medical Act 1983

15. General Medical Council (2011) Gateways to the professions: advising medical schools: encouraging disabled students London, General Medical Council.

16. A more detailed discussion on the difference between a personal grievance and raising a concern can be found in Speak up for a healthy NHS, produced by Protect.

17. For further information see *Raising and acting on concerns about patient safety*.

18. For further information see the Protect website.

19. General Medical Council (2017) *Confidentiality: good practice in handling patient information* London, GMC.

20. General Medical Council (2024) *Good medical practice* London, GMC, paragraph 62.

21. For example, national service frameworks and National Institute for Health and Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines.

22. For example, a patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation or socioeconomic status. For further information see the Equality Act 2010. If you are working in Northern Ireland, see The Gaps between GB and NI Equality Law (January 2011), which sets out the differences between the legislative framework and protections in Northern Ireland.

23. And those close to the patient where the patient lacks capacity or has asked you to communicate with a family member, carer or friend.

24. General Medical Council (2020) *Decision making and consent* London, GMC, paragraph 13.

25. General Medical Council (2024) *Identifying and managing conflicts of interest* London, GMC.

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Faculty of
Medical Leadership
and **Management**

Leadership and Management Standards for Medical Professionals

2ND EDITION



Source: https://www.fmlm.ac.uk

Faculty of Medical Leadership and Management

WHY WE NEED STANDARDS OF LEADERSHIP AND MANAGEMENT FOR MEDICAL PROFESSIONALS

The definition of the standards of medical leadership and management is long overdue, given the correlation between effective leadership and the quality of patient care. Currently, there is insufficient clarity regarding the expectations of doctors in leadership and management roles and no "gold standard" of achievement against which doctors can benchmark themselves and be measured.

This is particularly pertinent given the increasing accountability and responsibility that doctors have with respect to the effectiveness and efficiency of healthcare delivery and health advice, as well as safety and quality.

The UK medical profession has a distinguished international reputation for clinical standards; it needs to replicate this for leadership and management. This was emphasised in the 2012 *'Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry'* which called for stronger healthcare leadership and *"the recognition that healthcare management and leadership is, or should be treated as a profession"*.

Good medical leadership impacts positively at three levels: the patient, the organisation and the individual:

- **For patients**, there is a growing body of evidence linking good leadership to improved clinical outcomes. There is an inverse association between effective teamwork and in-hospital mortality[ii] and a positive association between leadership and the quality of patient experience in both primary and secondary care[iii iv]. Hospitals which boast high medical engagement deliver, as adjudged by the Care Quality Commission (CQC), high quality care and the converse is equally true[v].
- **Healthcare organisations** clearly benefit from good leadership by having better patient outcomes and also increased productivity. In high performing organisations, the levels of team working and medical engagement will be high resulting in continuous improvement in the value (quality/cost) of care for patients.[iv vi vii]
- **Individual doctors** also have responsibilities to themselves and to their teams for the reasons and evidence described above. Doctors, just like all members of multi-disciplinary teams, benefit from being well-led. Well-supported and empowered staff are more motivated and more productive, giving more discretionary effort and delivering a higher quality of care. All studies highlight the importance of development and leadership opportunities for doctors and effective selection and appointment processes for medical leadership and management positions.



Mr Peter Lees
Chief Executive and Medical Director, FMLM

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WHAT IS A STANDARD?

We have chosen to use the definition of standards used by the Safe Effective Quality Occupational Health Service (SEQOHS) - "A standard is something considered by an authority or by general consensus as a basis of comparison in measuring or judging adequacy or quality."[viii]

DEVELOPMENT OF THE STANDARDS

The FMLM standards are derived from, and build upon, earlier work including the General Medical Council's guidance, *Leadership and Management for all doctors*, UK national leadership frameworks and models, and research on medical leadership, management and engagement. The standards have also been informed by online and face-to-face consultation with over 600 individuals, groups and organisations and formal and informal discussions with a broad range of stakeholders.

WHO THE STANDARDS APPLY TO

The FMLM standards are designed specifically for medical professionals working in the UK, from all specialties, career stages and sectors including NHS, charities, private and independent companies, occupational health and pharmaceutical industry, armed forces, education and academia.

HOW THE STANDARDS CAN BE USED

Individual, organisation and group respondents to the consultation cited the following as some ways in which they would use the standards.

- Personal and professional development eg self-assessment, learning, reflection and 360 degree feedback, appraisal and revalidation
- Supporting, encouraging and coaching colleagues (including performance management)
- Driving conversations with groups of medical leaders about what the standards mean in practice and establishing a common language/ expectation
- Recruitment eg job descriptions, interview assessment, selection, induction
- Commissioning and guiding leadership development
- Informing education and training interventions including curricula development and courses
- Organisational development and as core principles for setting up and running services.

WHAT IS DIFFERENT IN THE OCTOBER 2016 VERSION OF THE STANDARDS

In 2016, FMLM has updated the standards in preparation for launching certification for medical leaders at team, operational and strategic level. An additional point (1g) has been added to the *Self-awareness* and *self-development* domain. Minor edits have been made to *Corporate culture, improvement and innovation* (3h). A new domain, *entitled System Leadership* has been added to highlight the particular skills associated with those who lead across systems.

THE LEADERSHIP AND MANAGEMENT STANDARDS FOR MEDICAL PROFESSIONALS

The standards are articulated as a set of core values and behaviors designed to work across all levels.

Building on suggestions from the consultation in 2014, FMLM has identified the core values and principles expected of doctors as leaders and reworded the behavioural statements to ensure they are observable, measurable, and assessable, while allowing scope for personal development.

FMLM has taken into account the tension between ensuring the standards are current and realistic as well as the value of them being aspirational and stretching.

FMLM believes an effective medical leader is defined by how and what they do under-pinned by why they do it. The 'why' is guided by the values espoused in the *7 Principles of Public Life*[ix] and the General Medical Council's *Good Medical Practice*[x]:

THE SEVEN PRINCIPLES OF PUBLIC LIFE:[IX]

1. **Selflessness** - Holders of public office should act solely in terms of the public interest.
2. **Integrity** - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
3. **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. **Accountability** - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. **Openness** - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6 **Honesty** - Holders of public office should be truthful.

7. **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

THE GMC GOOD MEDICAL PRACTICE:[X]

Knowledge, skills and performance

- Make the care of your patient your first concern
- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognise and work within the limits of your competence

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised
- Protect and promote the health of patients and the public

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity
- Treat patients politely and considerately
- Respect patients' right to confidentiality

Work in partnership with patients

- Listen to, and respond to, their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health
- Work with colleagues in the ways that best serve patients' interests

Maintaining trust

- Be honest and open and act with integrity
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Source: https://www.fmlm.ac.uk

Medical leaders should also be aware of the GMC guidance, *Leadership and management for all doctors*[xi].

The 'how' and 'what' medical leaders do is set out below as behaviours which can be observed, measured and developed.

BEHAVIOURS

1. SELF

Doctors must know and understand themselves, their impact on others and be constantly striving to improve. They must be resilient and consistently demonstrate the energy, drive and motivation to lead and work with others for consistently high and improving standards, and thereby improved quality of care for patients in all its dimensions (experience, effectiveness, safety).

SELF-AWARENESS AND SELF-DEVELOPMENT

a) Demonstrates a clear people and patient-centred approach, considering the impact of their style, decisions and actions on all those affected

b) Manages own emotions and adapts leadership style to have the maximum positive impact on others

c) Seeks and acts upon feedback from patients, colleagues and other professionals regarding own effectiveness and possible areas for development

d) Commits time to professional development and keeps own skills and knowledge up to date

e) Establishes and maintains strong professional and support networks

f) Acknowledges own limitations and prepared to seek support from others in order to achieve the best outcomes

g) Draws upon a range of leadership theories, principles and experiences to improve and innovate

PERSONAL RESILIENCE, DRIVE AND ENERGY

h) Takes full accountability for actions and decisions within own areas of responsibility

i) Remains calm and objective in situations of pressure or conflict

j) Sustains personal levels of energy and remains enthusiastic and optimistic in the face of setbacks

k) Has the courage to speak up and speak out when standards, quality or safety are threatened.

l) Constructively challenges others when there is an opportunity for improvement

m) Works to a high standard and earns the respect of colleagues.

n) Manages own time effectively, and is trusted by others to deliver commitments and promises.

Source: https://www.fmlm.ac.uk

2. TEAM PLAYER / TEAM LEADER

The effective medical leader has a sophisticated knowledge of establishing and leading teams and how to get the best out of them. Equally they know when to lead and when to follow. They are robust defenders of fairness and justice and strive constantly to create to optimal environment for colleagues to give of their best in the drive for improved clinical care.

EFFECTIVE TEAMWORK

a) Fully participates in multi-disciplinary teams in order to achieve the best possible outcomes for all those who use and deliver services

b) Asks others for their opinions and ideas, actively listens and takes their views onboard in order to deliver the best outcomes for all

c) Attracts and develops talent

d) Coaches to develop individuals to reach their full potential

e) Supports a diverse workforce and understands the value diversity brings to patient care

f) Demonstrates trust and respect for colleagues and is seen as a role model for effective team-working

g) Empowers and motivates others to deliver, improve and innovate

h) Delegates effectively, sets clear objectives, provides feedback, and holds people to account

i) Actively manages poor performance and behaviour

j) Is supportive, available and approachable.

k) Responds quickly and positively when asked for help

l) Celebrates success

CROSS-TEAM COLLABORATIONS

m) Identifies opportunities for collaboration and partnership, connecting people with diverse perspectives and interests

n) Seeks out beyond the immediate team and professional area for new perspectives, ideas and experiences and shares best practice, incorporating this to enhance quality and delivery of services

o) Engages the wider healthcare community in the teaching, training and support of own work and that of colleagues

p) Openly shares own networks with colleagues and partners to improve information, influencing

q) Connects individuals, teams and organisations for mutual benefit.

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3. CORPORATE RESPONSIBILITY

The effective medical leader understands and contributes positively to the strategic direction and operational delivery of the organisation in which they work. They espouse and practice the seven Principles of Public Life[ix] and Good Medical Practice[x]. They can successfully navigate the competing demands between the needs of the individual and the needs of the population. Furthermore, they can successfully balance their role in day to day delivery with a focus on anticipating future challenges and future innovation.

CORPORATE TEAM PLAYER

a) Ensures adherence to the principles of good corporate and clinical governance

b) Understands the competing demands for resources and actively supports fair and appropriate allocation

c) Makes clear, transparent evidence-based decisions even when faced with situations of ambiguity and uncertainty

d) Considers, assesses and manages potential risks when making decisions that impact upon patients, colleagues and their organisation

e) Participates in wider organisational initiatives that enable and promote excellence in healthcare

f) Recognises and can navigate professional and political tensions

CORPORATE CULTURE, IMPROVEMENT AND INNOVATION

g) Relentlessly identifies and supports opportunities for improvement

h) Understands and successfully applies key concepts and principles underpinning the creation, validation, translation and dissemination of innovative ideas and practices

i) Motivates and inspires others to achieve high standards and improve services

j) Engenders and is a role model for an organisational culture that values diversity, learning, reflection and feedback, transparency, openness and candour

k) Is forward thinking and helps the organisation to prepare for new challenges and innovate.

Source: https://www.fmlm.ac.uk

4. SYSTEM LEADERSHIP

The effective medical leader understands and contributes positively to the healthcare system. They are adept in dealing with complexity and ambiguity. They can translate policy into practice and negotiate effectively with organisations across the system to meet the needs of the population.

SYSTEM LEADERSHIP

a) Demonstrates effectiveness in contributing to and influencing policy development

b) Seeks to positively influence strategy and culture

c) Demonstrates ability to negotiate effectively

d) Demonstrates appropriate situational awareness in the handling of complex, challenging or ambiguous circumstances

e) Demonstrates appropriate sensitivity when working with a wide range of stakeholders

f) Demonstrates assertive and respectful communication taking into account the perspectives, considerations and feedback of stakeholders when formulating strategy or policy.

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SUPPORTING TOOLS AND GUIDANCE

In March 2016, FMLM launched a 360 feedback tool for individuals at team, operational and strategic levels. This is available on **www.fmlm.ac.uk/FMLM360**

FUTURE WORK

The FMLM will continue to work with stakeholders on other areas of support to implement the standards. In 2016, FMLM will launch a certification system where individuals can be assessed on their achievement against the standards and recognised accordingly. There will be guidance produced for organisations to help support and develop doctors as leaders at each level.

SUMMARY

These standards are not a static document. FMLM is committed to regularly reviewing and refining all aspects. The intention is to be aspirational and stimulate improvement and consistency in medical leadership; feedback from individuals and organisations has been constructive and supportive. However, no matter how erudite the end product is, it is what we all do with the standards that will make the difference.

FMLM is confident that this is an essential step towards professionalising medical leadership and management as recommended in the Francis Report. Furthermore, we are confident that enhanced medical leadership will improve the quality and outcome of patient care, improve organisational performance and play a major role in the relentless drive to make UK healthcare the best in the world.

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The Faculty of Medical Leadership and Management (FMLM) supports the delivery of better healthcare outcomes for patients in the UK by developing and promoting excellence in medical leadership and management through networks, resources and career opportunities for doctors of all grades and specialties.

FMLM has launched the leadership and management standards for medical professionals and supports a diverse and dynamic membership community and is the UK professional home for doctors and dentists who are both current and aspiring medical leaders and managers.

For more information or to download further copies of this review please visit:
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Citation: Faculty of Medical Leadership and Management (2016) Leadership and management standards for medical professionals (2nd ed.), London: Faculty of Medical Leadership and Management.

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Source: https://www.fmlm.ac.uk
Designed and printed by Rapidity. October 2016

INQ-31067



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

A Time for Revolutions — The Role of Clinicians in Health Care Reform

Ara Darzi, M.D.

William Beveridge, the economist whose 1942 report led to the founding of Britain's National Health Service (NHS), famously said that "a revolutionary moment in the world's history is a time for revolutions, not for patching."[1] Given the combination of the global downturn and the time bomb that is health insurance costs, there is no denying that health care in the United States has reached such a moment. This matter is too important to be left to the politicians and policymakers; there is an urgent requirement for professional clinicians to step up and lead the debate.

President Barack Obama has brought health care reform to the forefront of people's minds, and it is now a matter of when, not whether, change will come. Repeatedly quoted statistics — on the numbers of uninsured Americans, for example, or the high, rapidly growing expenditures on health care — leave no room for ambiguity, and groups across the political landscape recognize that the U.S. health care system is unsustainable in its current form.

Every country in the developed world confronts a similar challenge right now: finding a way to create a well-resourced but sustainable system that provides care of the highest quality to those who need it. One would be hard-pressed to find credible opponents — regardless of their political stripe — to the goal of providing "universal health care." The disagreement arises when the discussion turns to the best way to achieve this aim. Each country needs to discover the formula that suits it best.

The outcome of health care reform in the United States will no doubt be very different from that in Britain, despite what some U.S. lobbying groups would have Americans believe. Britain's NHS lies at the opposite end of the spectrum from the current U.S. system, in terms of both its structure (a tax-funded public program as opposed to mainly private, employment-based insurance) and the problems it faces (historically, a lack of resources and slow uptake of new treatments as opposed to bulging costs), but in the late 1990s Britain had to confront reform on a scale as challenging as that being contemplated in the United States today.

In 1997, Britain had a new government, which had inherited a health care system that was chronically underfunded and suffering from a lack of capacity, with average waiting times of 18 months from referral to treatment. Funding for 1997 was £35 billion; for 2010 it is £110 billion, and waiting times are now as short as

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INQ-31068

they've ever been — 10 years ago, patients waited approximately 18 months for treatment, and now they wait only a few weeks. Although both the causes of and responses to reform were very different from those in the United States today, the NHS's experience can provide some valuable lessons.

A key insight to be gained from the post-1997 NHS "revolution" is that it is important for clinicians to be involved in both informing and leading change. Successive attempts at top-down regulation and reform in Britain damaged clinicians' morale and bred distrust between them and politicians. Not having been central to the decision making, clinicians subsequently didn't trust the proposals or fully understand their purpose.

In the late 1990s, Britain had to confront reform on a scale as challenging as that being contemplated in the United States today.

Last year saw the publication of the report *High Quality Care for All*, of which I, as a health minister, was lead author. Based on the findings of the Next Stage Review conducted by 2000 clinicians from all fields of care, it redefined the NHS, setting out a bold 10-year vision rooted in evidence of what matters to patients, the public, and NHS staff members. It established the mission of providing high-quality care — driven by clinical leadership, best evidence, and innovation — as the organizing principle of the service and has put the NHS firmly on the path toward systemic improvement in outcomes and efficiency.

Similarly, placing professional responsibility for health outcomes in the hands of clinicians, rather than bureaucrats or insurance companies with vested interests, must be the ambition of any new structure in the United States. Such an approach will lead to a health care system that has a democratic mandate and clinical leadership.

U.S. clinicians should bear three things in mind as they consider how to approach this debate. First, politicians must be made to recognize the role of clinical leaders in shaping a transformed but effective health care system. If clinicians can redefine the debate so that it focuses first and foremost on patients and health outcomes, that will provide a strong common purpose for efforts to tackle the challenges of funding structures and access to care.

Second, clinicians need to be involved in defining the link between funding and the care provided. It is for the patients at greatest risk that the U.S. system has the greatest difficulty providing access. The United States needs to find a model that best meets its needs while also being socially acceptable. Clinicians will have to find a brave voice if funding structures are to be reviewed in a way that puts quality of care before financial gain.

Finally, clinicians must educate both policymakers and the wider public about appropriate levels of care. Health care systems all suffer from a disproportionately heavy focus on the treatment of acute illness and injury — the type of medical work glamorized on television — which consumes by far the most resources. But primary care accounts for most of the health care that is delivered: nearly a billion visits are made to physicians' offices every year in the United States, but there are fewer than 40 million hospital stays. The current system of insurance and referrals can often lead to the unintended consequence of unnecessary referrals for the most expensive tests and treatments. Health problems related to lifestyle, such as obesity, smoking, and diabetes will be solved not by high-tech robotics and bigger hospitals but rather through access to family doctors, innovations in public health, and lessons from the emerging discipline of behavioral economics.

The best outcomes can be achieved only when the system itself is healthy and built on real partnerships between patients and clinicians. Britain's experiences to date, both good and bad, have proved this to be true. Building a health care system centered on clinical professionalism and responsibility is the only way to achieve such partnerships and to ensure that all patients are well served.

Beveridge's characterization of revolutionary moments echoes in our ears today as the NHS goes through a period of radical reform. And as the United States, for its part, does what it does best — summoning up its revolutionary spirit — clinicians should step up and shape the debate, not wait to be handed a possibly misguided reform as a fait accompli.

No potential conflict of interest relevant to this article was reported.

From the U.K. Department of Health and Imperial College — both in London.

This article (10.1056/NEJMp0905707) was published on July 22, 2009, at NEJM.org.

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Foreword from General Sir Gordon Messenger

In October 2021, the Secretary of State asked me, alongside my now good friend Dame Linda Pollard, to examine the state of leadership and management in the health and social care sector. A daunting remit, but one which recognised the impact that good leadership at every level can make in a workforce which has been under incredible pressure in recent years and where the demands on its commitment and goodwill show no sign of slacking.

As an outsider with limited sectoral experience, it was with some trepidation that I set off on our listening and learning phase; a perhaps unwelcome interloper at a time when everyone was understandably focused on the pandemic and its consequences. Yet, throughout, I have encountered nothing but friendliness, candour, self-reflection, pragmatism and support from the impressive array of experts, front-line staff, academics, service users and leaders who willingly gave us their time to share their views. I have always held our health and social care workforce in the highest regard, yet my respect and admiration has deepened through witnessing their selflessness, professionalism and resilience first-hand. My thanks go to all those we spoke to, and my apologies to those we unwittingly missed.

Of the many telling observations we have heard, 2 stand out as almost universal; firstly, the very real difference that first-rate leadership can make in health and social care, with many outstanding examples contributing directly to better service, yet; secondly, that the development of quality leadership and management is not adequately embedded or institutionalised in our health and care communities. We have consequently focused our findings on areas which improve awareness of the impact that good leadership can have, and which instil it as an instinctive characteristic in everyone, not just those with the word in their job title.

Huge variety exists in the way primary, secondary and social care is structured and governed, so it has proved difficult to identify sensible interventions that have consistent relevance and impact across the board. The NHS is itself far from a homogenous unified organisation but rather a federated ecosystem where complex tribal and status dynamics continue to exist. Given the clear benefits of cross-boundary teamwork and collaborative behaviours, everything should be done to encourage greater parity of esteem, conditions and influence between sectors and, within secondary care, a re-balancing of the focus on acute trusts to the benefit of their community, mental health and ambulance trust counterparts. The vast majority of health and care delivery never touches the acute sector, and it is in the interests of all to keep it that way, so more equitable representation

and empowerment must be a key enabler to enhanced collaboration. Equally, the more that can be done to instil locally a culture of teamwork, understanding and shared objectives across the primary, secondary and social care communities, the better will be the nation's public health outcomes.

To those of our recommendations which require time and resource to implement, I predict a partially understandable reaction that the current pressures on the system preclude investment beyond the urgent. My response is that a well-led, motivated, valued, collaborative, inclusive, resilient workforce is 'the' key to better patient and health and care outcomes, and that investment in people must sit alongside other operational and political priorities. To do anything else risks inexorable decline.

I would like to thank the review team who have supported me so energetically and ably. Without their insight, industry and support, I would still be lost in the foothills of the challenge set me and will be forever grateful for their patience and commitment over the last few months. A special mention must go to my co-lead, Linda Pollard, who has contributed so much despite also holding down a crunchy day-job. Her wisdom, decency and forthrightness have shone through every day and, if this review achieves what it sets out to, the plaudits are hers.

Sir Gordon Messenger
8 June 2022

Executive summary

For a report like this to have the impact intended, it needs to speak to the community it affects. It must be supportive but honest. It must recognise the challenges and the context faced, but it cannot duck the difficult or uncomfortable. It should respect the everyday commitment, determination and goodwill of leaders and staff at every level to improve outcomes and experience for patients and service users yet also, through well-intentioned, constructive criticism, aim to provide a framework for improvement.

In that vein, we must confront the fact that there has developed over time an institutional inadequacy in the way that leadership and management is trained, developed and valued. Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or

rewarded in a system which still relies heavily on siloed personal and organisational accountability. Very public external and internal pressures combine to generate stress in the workplace. The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. We experienced very little dissent on this characterisation; indeed, most have encouraged us to call it out for what it is.

These symptoms are not, we would observe, necessarily the fault of historical or existing leadership teams or their staff. They are the result of a combination of factors over many years; some structural, some cultural, some emanating from behaviours at the top, including politicians, some born of complex inter-professional and status issues in the workplace. The important conclusion, however, is that they should not be tolerated as they directly affect care of the service-user as well as the staff, and that they can be tackled but only through determined cultural change from the top of the system to the front-line.

The recommendations of a one-off review cannot provide all the necessary ingredients for such a shift, but we do attempt to identify key interventions which we hope will deliver momentum and scale. We identify the point of entry as a critical opportunity to set cultural and behavioural expectations, and to emphasise that how one behaves is as much a component of professional acumen as what one does. We propose a locally delivered mid-career development event, designed to bring together professionals from all parts of health and social care around the triple lens of collaborative leadership, broader cross-sector awareness and understanding, and behavioural expectations. We encourage the medical profession to examine honestly their role in setting cultures, given their unique influence in the workplace dynamic. Most critically, we advocate a step-change in the way the principles of equality, diversity and inclusion (EDI) are embedded as the personal responsibility of every leader and every member of staff. Although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we would call out race and disability as the most starkly disadvantaged. The only way to tackle this effectively is to mainstream it as the responsibility of all, to demand from everyone awareness of its realities, and to sanction those that don’t meet expectations. EDI should become a universal indicator of how the system respects and values its workforce, and the provision of an

inclusive and fair culture should become a key metric by which leadership at all levels is judged.

Beyond cultures and behaviours, we chose to focus on the current absence of accepted standards and structures for the managerial cohort within the NHS. With known exceptions, it has long been a profession that compares unfavourably to the clinical careers in the way it is trained, structured and perceived, and we received strong feedback from managers at all levels that greater professional status and more consistent, accredited training and development are required. This training must be aligned to professional skills required in the future, including digital and transformation, as well as core managerial delivery. We make recommendations to that end.

This approach to career management spills over into how individuals' particular skills and talents are encouraged and developed, and we heard frequently that managers do not always feel institutionally supported in their career choices. We did not find much evidence of a systemised career management function which exists to grow the right experience and talent and to place it where it is needed most. While there are many examples of world-class leadership in the NHS, we would observe that it often exists through the endeavours of an individual rather than as a consequence of proper talent management. The flip side of this opportunistic approach to succession planning is that it lacks equity and does not guarantee that the most deserving leaders reach the top. We would include non-executive director (NED) appointing in the same bracket. Despite the pivotal governance role of boards, the selection and development of NEDs is currently too localised and arbitrary to assure the right balance of skills, experience and background around the table.

It is clear that effective leadership can be an important, but by no means the only, component in addressing the thorny issue of geographical variation in the quality of care. We welcome the ongoing efforts by the current leadership to tackle this, and provide recommendations which seek to provide effective incentives for the right talent and teams to commit to these challenges, along with a package of support to give them the best chance of success.

The last section of the report is devoted to implementation, recognising that anyone can have great ideas but, if they don't lead to action, they are for nought.

Summary of recommendations

1. Targeted interventions on collaborative leadership and organisational values.

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

5. A new career and talent management function for managers

Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

6. More effective recruitment and development of non-executive directors

Establishment of an expanded, specialist non-executive talent and appointments team.

7. Encouraging top talent into challenged parts of the system

Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

1. Introduction

Effective leadership creates successful teams, and successful teams drive better outcomes. The best organisations are those which invest in their people to unlock their potential, and which build strong teams around a unifying purpose. The most successful are those which also foster leadership and accountability at every level, and where everyone is encouraged to become an agent for something bigger than themselves. This should be our goal.

There are many examples of inspirational leadership within the health and social care sector, delivered in the face of enormous pressure. From ward to board, from the manager in a care home to the receptionist in a GP surgery, great leadership and personal example are being exercised daily in pursuit of the best possible outcomes for patients and public health. But such qualities are not universal and nor are leadership and management skills engrained as the basic building blocks of organisational success, as they perhaps are in other sectors.

We need to recognise that the context for change is highly challenging. External pressures such as manifold performance metrics, stringent regulatory requirements, and short-term political demands, combine with internal pressures such as staff shortages, budget issues, sectoral disparity

and pandemic-induced backlogs to create a very difficult backdrop for compassionate leadership and collaborative, inclusive behaviour to thrive. These pressures can lead to 3 unwelcome outcomes:

- they drive a singular fixation on the task in hand, often to the detriment of nurturing the team and supporting its individuals. Over time this has certainly contributed to poorer experiences in the workplace and worsening outcomes; manifested by higher absence rates, deteriorating staff engagement and performance downturns
- they create an organisational instinct to prioritise the needs of the system and its hierarchy over a focus on the better patient and public health outcomes
- they can feed a sense of futility and helplessness in the workforce because individuals perceive they lack the tools or ability to rectify what they know is wrong

To reverse these trends requires a re-calibration towards building stronger teams and a renewed sense of respect and value amongst an empowered workforce, delivered through committed, compassionate leadership from bottom to top. The hard fact is that this must be prioritised alongside the pressing operational needs, and we should be ready to deploy the justification that spending time and resource on looking after the workforce will quickly repay the investment through improved support to patient and service users. Equally, the best way to root out inefficiency and waste is to encourage a collective accountability to tackle it, through empowerment and teamwork at all levels. In every way, investing in leadership and team-building makes economic sense.

Every opportunity must therefore be taken to embed such behaviours so that they become institutionally valued and instinctive to all. And right now we suggest a number of powerful factors combine to provide a generational opportunity to make the necessary cultural shift, owned and driven by the leadership at all levels of healthcare, social care and government:

- structurally, the introduction of the Health and Care Bill and the advent of integrated care systems (ICSs) provide greater opportunity to promote cross-sector collaborative and inclusive behaviours to deliver better system outcomes. The integration white paper further reinforces the value of close, inter-professional working at local level
- organisationally, the rationalisation over the coming months into a unitary NHS England (NHSE) provides the opportunity to align behind a core set of values and a common leadership culture, with the potential for spill-over benefits into both primary and social care.

Also, the emerging NHS operating model should provide the framework to align responsibilities, accountabilities and authorities

- internally, the NHS People Plan, People Promise and Our Leadership Way provide the manifesto for change in the health sector; they deserve time to bed in and, if owned at every level and not perceived as merely more guidance from the top, have all the right components to motivate change
- culturally, a positive legacy of the pandemic is that it has changed the workplace dynamic across health and social care; driving accountability downwards, encouraging innovation, magnifying the value of teamwork including across sectoral boundaries, and strengthening a workforce sense of community through common experience and shared hardship. This sentiment should be capitalised upon

This introduction sets out both the opportunities and challenges which face our health and social care community. A one-off review like ours is unlikely to drive the deep cultural change needed – that must be the responsibility of existing leaders at all levels – but our hope is that our recommendations can provide the necessary frameworks and momentum to take the plunge.

Methodology

We kept our approach simple; form an inclusive and diverse team, consult as widely as possible, remain transparent throughout. Our excellent team, brought together at short notice, included representatives from the Department of Health and Social Care (DHSC), NHS England, Health Education England, NHSX and social care leaders, as well as clinicians, managers and academics – all bringing their own lived experience and personal knowledge of the health and care system. An early decision to ensure very strong EDI expertise in the core team proved consistently valuable.

Our ‘listen and learn’ phase was extensive, engaging with more than 1,000 stakeholders on over 400 different occasions, plus welcoming contribution from all via an open email address. We heard from all parts of the system and across the breadth of primary care, secondary care, local government, public health, social care, charity sector, patients and people who draw on care and support. We sought to avoid speaking only to the well-performing, better-known parts of the system, and actively encouraged constructive challenge and dissent throughout, including the establishment of a

challenge board which proved highly effective. COVID measures prevented us from visiting many places personally, yet the generosity of people at every level to give up their time was highly encouraging and indicative of their desire to drive positive change.

We have attempted to limit the number of recommendations to a digestible number, recognising that implementation on too broad a front can quickly dilute impact. Instead, we have invested in working closely with those who will need to own the recommendations if they are to take root. Where appropriate, we have tried to align with existing initiatives and to support the conclusions of previous reviews. This includes Tom Kark's recommendations regarding the fit and proper persons test for directors, which we feel are necessary alongside ours to ensure poor leadership is dealt with effectively. We have tried to avoid being over-specific in framing our findings, in the knowledge that subsequent co-creation is the best way both to ensure buy-in from the communities they affect and to minimise unforeseen disruption during inception.

Scope

Our terms of reference encouraged us to examine the nature of leadership across the entirety of health and adult social care, and from the top to the bottom of both. With a remit of this scale, we have necessarily focused in on a few key themes which we hope will yield the largest impact. One challenge we faced was the very different structures, governance and accountabilities that co-exist across sectors, and it quickly became clear that the more hierarchical secondary care sector has more identifiable levers of change than the flatter, dispersed, multi-provider structures of the wider health and care landscape, particularly in primary care and social care. This can have the effect of making it harder to enact universal change in the latter sectors, and can also heighten the risk that individuals find opportunities for development more difficult to access.

We have attempted, with some success, to avoid a disproportionate focus on secondary care in our thinking and many of our recommendations are of relevance across all sectors, particularly those which address cultural and behavioural development. But we reluctantly conclude that we have not done them full justice and would advise further work to identify how the impact of better leadership and management can be applied most effectively in our primary and social care communities. Specifically, we commend the focus on developing primary care leadership in the work that Dr Claire Fuller is leading on a stocktake of primary care within ICSs. This

will provide specific and practical advice to the ICS chief executives on how they can accelerate implementation of integrated primary care and prevention ambitions in the NHS Long Term Plan, which will include focusing on the importance of nurturing primary care leadership in their own systems. On social care, we have sensed a strong appetite amongst both local government and independent providers for collective, pan-sector leadership and management development, and strongly support the need for greater parity of investment in social care leadership.

2. Findings

This section sets out the key findings from our review which ranged both widely and deeply in health and social care. We encountered many examples of outstanding practice, including the difference that good, mature, collaborative working can make. Yet we also found areas where change and improvement are necessary to ensure leaders and managers are supported to deliver the best possible care. In that respect, while some of our observations may be perceived as critical or negative, they are by no means universal. But we heard them often enough to call them out.

Cultures and behaviours

In this area of cultures and behaviours, 2 broad themes emerged: the culture of collaboration and the culture of respect. Both themes emanate from and determine how people treat each other and service users; both affect the quality of care and outcomes for service users.

The culture of collaboration

We found that the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment. The system is undergoing a fundamental change from a competitive to a collaborative ethic, and behaviours need to reflect this. Decision-making too often relates to a narrow and limited set of accountabilities that do not allow, encourage or reward collaboration. We recognise that this is a direct result of how performance is currently measured, but strongly believe that a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes.

We saw that the urgent tends to eclipse the important. Staff habitually respond to pressures inherent in the workplace by prioritising the task in hand rather than the team and individuals who together complete that task. This is unsustainable. Principal among the many agents that cause reactive rather than constructive behaviours are those pressures from above that force upward-looking rather than outward-looking responses. Some staff, for example, are presented with the responsibility to meet an external metric while lacking the ability or resource to meet it, while others operate freely without oversight in isolated areas. We saw accountability without authority, and vice versa.

Finally, we saw that leadership itself is undervalued as a way of setting the context for collaboration. Leadership is viewed as the responsibility only of those in specific line manager or senior leadership positions, rather than as a quality that runs instinctively through the entirety of the workforce. We found no consistent view of principles for collaborative or systems leadership; current models extol the virtue of certain behaviours but lack a structured framework.

The culture of respect

We heard too frequently that poor inter-personal behaviours and attitudes were experienced in the workplace. Although by no means everywhere, acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system, as evidenced by staff surveys and several publicised examples of poor practice. This exists at the micro-level, in individual workplaces, and across sectors, where the enduring lack of parity of esteem, conditions and status between healthcare and social care remains a blight on effective collaborative working.

How an organisation performs and behaves in relation to EDI is a clear indicator of its maturity and openness. Further, it will be a clear determinant of how an organisation fares in a rapidly changing social and work context. In this regard, we found that EDI, which is about respectful relationships and underpins a wider culture of respect, is partial, inconsistent and elective. In some places it is tokenistic.

Improving EDI is also a way of reframing career progression. The latter frequently depends on chance, contacts, regional variation, available time and budget. By training leaders to identify where such unfairness exists, access to opportunities will become allocated more fairly, and career progression will be determined more equitably.

In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report. We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective.

The improvement of organisational learning within health and social care deserves a deeper examination. Too often we encountered limits on the freedom to try without fear of failure, and a willingness to tolerate poor practice while expending energy on workarounds.

Implications of our findings

First, on collaboration. The NHS is a complex ecosystem where personal, professional and organisational accountabilities flow vertically through distinct silos. Similarly, social care is a complex landscape of overlapping public, private, and charity provision. The system needs mechanisms to build and reinforce horizontal, collaborative decision-making; within and between individual organisations, and across the full health and social care sector [see recommendations 1, 2, 3, and 4]. To deliver this, we identify 2 critical points of intervention in careers to embed the necessary behaviours and to align expectations: set culture and improve knowledge [see recommendation 1].

Second, shared greater awareness of the entirety of health and social care would lead to greater empathy and understanding. The system must improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of system, and to value diverse professional approaches. ICSs and integration at place provide excellent opportunities to test and prove the value of collaborative and inclusive leadership.

Third, we think that EDI must be embedded and mainstreamed as the responsibility of all regardless of role, and especially leaders and managers from front line to board. This must include the practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics. Health and social care must work harder at EDI, recognising it is important in its own right, and key to how seriously an organisation treats the lived experience in the workforce and upholds practices that deliver equitable outcomes for all. Beyond mainstreaming, we also recognise the need for positive action [see recommendations 1, 2, 3, 4, 5, and 6]. We are not advocating for additional EDI professionals; indeed we would anticipate a reduction in numbers over time as leaders demonstrate that they are equipped with the

right skills to address inequality and create inclusive working cultures for all.

Standards and structures

The practice of management relies on both standards and structures; it emerged through our engagement that these are currently either insufficient or absent. Our observations cover the NHS specifically, but we recognise that many of these issues are equally relevant in wider health and social care. We recommend further work to investigate the levers to address common challenges, to ensure shared learning across health and social care can be applied with the most impact.

We found that management tends not to be perceived – formally or informally – as a professional activity. Management lacks the status enjoyed by the established professions in health and social care. We heard that this derives from the absence of acknowledged, universally applied standards to achieve agreed levels of behaviour and competence; and from inadequate, unstructured career support. Management can therefore appear as an under-valued career, rather than one at the very heart of great care.

We found inequity in how different managers are perceived; for example, the NHS Graduate Management Training Scheme (GMTS) is highly regarded, but it is unfair that participants are frequently treated as elite purely by virtue of having undertaken the scheme. Managers who do not join via GMTS, often equally talented, do not benefit from the same profile or opportunities. Lateral entrants are often inadequately inducted into leading and managing in context; and skills gained outside the sector, including those who have trained overseas, are not always fully valued. Clinicians who choose to take on leadership roles in addition to their clinical work told us they had little to no specific training to prepare them.

Management and leadership training, although excellent in some instances, is not based on any consistent or agreed universal standards, is an unhelpful mix of accredited and unaccredited courses and opportunities to access training are inequitably applied. Too much management and leadership training and development, and associated cultural transformation work, is piecemeal, partial and isolated. This whole landscape needs tidying.

There are excellent examples of talent management within organisations, but they are too widely scattered and are rarely completely inclusive. We consistently heard from managers that the lack of structure means career opportunities can appear to be linked more to who one knows and the network one is able to create, than to one's skills and experience. We saw that career management does not start early enough, and this leads to narrowing career paths to the detriment of wider experience. Career management needs to support those in their first role as much as those at mid and later career; too often individuals are recruited to jobs, rather than recruited to careers.

We found a lack of consistency with appraisals – and in some areas, these were absent altogether. Appraisals can range from a performance review and a development conversation to a simple tick-box of tasks completed. Development needs are either focused on individual wants with no relationship to organisational goals, or are neglected in favour of immediate pressures. It was rare to hear of appraisal linking individual, team, organisational and system goals effectively.

Finally, workforce data. Currently, data is not collated and exploited to the benefit of the individuals, teams, organisations, systems or regions as a whole. The result is that excellent talent remains invisible, career support remains opportunistic, talent-hoarding becomes the privileged domain of those that can, and the system struggles to deploy the best people to work where their skills are needed most.

Implications of our findings

There is a need for universal standards, covering practical, procedural and behavioural elements with the aim of ensuring a clearer set of expectations, and in turn equitable recognition and parity. Proper standards require consolidation and coordination; both are lacking in the current preference for multiple competency frameworks and lists of competencies of variable quality. These standards need to apply to and work for all, including those working part time or flexibly.

Consequently, there is a need to develop a formal training curriculum for managers, to deliver against these standards [see recommendation 3]. This requires larger-scale delivery of training to a pre-determined community, as opposed to the current system which is based on availability and opportunity. Completion of this training should be a pre-requisite to advancement to more senior roles, as current gateways can be arbitrary and inconsistently applied. The modules within this curriculum must allow for different career paths and preferences, but also be accredited to ensure high-quality consistency which is currently lacking. New accreditation could

provide alternatives to master's-level expectations stipulated in many Agenda for Change job descriptions currently and will need to take account of prior learning within the bench marking required for the NHS.

We heard that more can be done to support and guide individuals in how they make their career choices. While career and talent management should remain the responsibility of all line managers, organisations and systems, we can see real value in greater oversight at regional level. This new, regional function should have direct responsibilities as well as strategic oversight of managerial careers, working in close partnership with all parts of the system including the system chief people officers or equivalent and organisations' human resource directors [see recommendation 5]. This function becomes the focal point for the NHS human capital in the region with vital responsibility for the collection of data.

To be truly effective as a talent management function requires a more consistent and effective approach to appraisals, including better training for line managers in their delivery [see recommendation 4]. There is currently too much variability in the quality, effectiveness and outcomes [see recommendation 2].

Wider observations

As well as the findings outlined above, we have a number of other observations.

Regulation and oversight

We found that there is a positive view that the CQC can influence collaboration across the whole of health and social care through its inspections, and welcome its increasing focus on teams and systems. The well-led domain of CQC reports can develop its focus on culture and values rather than on managerial processes, and thereby reflect collaborative, compassionate and inclusive leadership in organisations. A judicious use of metrics and data can be a uniting and enabling agent, particularly if they are the basis for open and honest discussions; however, we also heard that over-emphasis on metrics can be burdensome and counter-productive. Where quality of care falls below what is required, the tone and outcome of regulatory visits can leave leaders feeling isolated and unsupported. With this in mind, we welcome the shift in emphasis from a punitive model to a remedial one.

Open, honest organisational learning here is priceless. We heard that good organisations have a positive relationship with regulators, while those performing less well often wait to be told what to improve. Transparency, and the ability to learn from mistakes and respond without blame, are all necessary for quality improvement; regulators can influence and promote both professional and organisational behavioural changes necessary. Readiness to seek help is a vital first step towards improvement and the route to external support must be clear, timely and stigma-free [see recommendation 7].

The role of the professional regulators (General Medical Council, Nursing and Midwifery Council and others) relates primarily to individuals but is increasingly important in assuring organisational quality. To ensure better read-across to professional standards, we would promote collaboration across all regulators in developing the management standards and the training materials for managers.

Clinical leadership

We found that the interaction between the clinical community and the rest of the workforce is a key element in setting the right cultures and behaviours. The authority and influence that doctors have both in society and within the NHS, means that the medical profession does have a unique responsibility for leading behavioural change where necessary and supporting a positive culture within their sector where all staff flourish.

Clinicians bring a perspective that spans patient interaction and wider population health needs. Done well, their knowledge and innate understanding of their ‘clinical tribes’ can be a huge force for good, but we have equally seen evidence that it can lead to entrenchment and loss of team ethos overall. We encountered the flawed assumption that simply acquiring seniority in a particular profession translates into leadership skills and knowledge; this both reduces the quality of leadership overall and can drive a sense of frustration for those individuals. Doctors are often co-opted for management roles, particularly early in their consultant career, for which they often feel inadequately prepared in comparison with their clinical training. An associated lack of fulfilment can set the tone for their approach to management later in careers.

We heard from allied health professionals that the lack of visibility of leaders from their professions on boards created a sense that careers in management would be limited. Senior nurses talked about ‘going to the dark side’ as a comment often made when they moved into senior management roles, although nurse postgraduate training does provide

elements of management learning. Again, the approach was felt to be ad-hoc and inconsistent.

Overall, even the most successful of clinical leaders reported that their career trajectories had been serendipitous, and that their knowledge was acquired in unstructured opportunities in comparison to their professional training.

We know the system will benefit from well trained, enthusiastic, supported clinical managers and leaders. Alongside the provision of national standards for NHS managers [see recommendation 3], education providers from undergraduate through to postgraduate education, working with professional regulators, have the opportunity to embed and align learning to prepare the clinical professions as future leaders.

The consistency of learning management and behavioural skills is often subsumed by clinical pressures. Extending access to the proposed management training bundles [see recommendation 3] provides an opportunity for a more structured and collective approach to management training for all clinicians. For the medical profession, this must include the trained medical workforce (that is, GPs, consultants and doctors in the staff and associate (SAS) grades). There are different challenges in primary care where we heard there is significant variation in leadership structures within and between GP practices, in their networks. We were told that it is unclear to a newly qualified GP which route provides the best leadership experience in comparison to the traditional clinical director to medical director pathway in hospitals. The new place partnership boards and integrated care boards should provide the outlets that are currently lacking for primary care and public health leaders. The same should be true for local social care leaders.

Leadership delivery in the future

We believe the current climate, including the move towards health and care integration and the work currently underway to merge the arms-length bodies and create a new NHSE, generates opportunity for a fresh approach to preparing leaders and managers in the future.

With regard to leadership development, it is entirely right that it is the role of the centre to demonstrate and drive the appropriate cultures and behaviours, around a set of unified values and purposes. We would observe that this is easier to achieve in the more unified structures of the NHS than in social care, and would encourage investment in setting common cultures and purposes across health and social care as a whole [see recommendation 1]. Further, as knowledge content changes with the

impact of digital health and other innovations, future leaders need access to a very different curriculum.

In the context of the NHS and social care, we heard that leadership development is currently uncoordinated and inconsistent, with a crowded landscape of different guidance, agencies and oversight. We believe that rationalisation and accreditation of training opportunities is required, at a greater scale that serves the entire system [see recommendation 3]. There are some excellent leadership development offers available, but they are offered on a ‘pull’ basis (that is, available but not expected), rather than a ‘push’ basis where there is expectation that prescribed cohorts will participate. We advocate a shift to the latter.

Collaborative action from the centre, the regions and at local level in healthcare will move the system from being an opportunistic, ‘pull’ model described above to one that sets broad, core curricula and manages accredited delivery, recognising that a strong local flavour needs to exist in the detail. The existing leadership delivery models, particularly in the NHS, require change to reflect this. Greater alignment of leadership training and development across health and social care sectors would yield immediate benefit.

3. Recommendations

We think some of the changes we recommend are gradual, subtle, and precise; we think others are immediate, radical, and wide-ranging; we think all are necessary. By driving improvement in leadership and management, we are confident that their implementation will have a positive outcome on both public health outcomes, productivity and efficiency.

1. Targeted interventions on collaborative leadership and organisational values

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

As the delivery of care transforms, a move to greater integration, different skills, and more collaborative behaviours is required. This includes a need

for improved, standardised training on equality, diversity and inclusion [see recommendation 2] as part of a new approach to the production of skilled managers. There are 2 critical waypoints where a significant impact can be made with new training interventions:

- at entry into a career in health and social care, by whatever route
- at mid-career where individuals often refine their ambitions and career trajectories

What is needed here does not currently exist: this is not about scaling any existing training programmes.

Entry level

The scope here is intentionally broad, capturing the breadth of those who enter a role in healthcare, social care, local government, and relevant voluntary and private sector organisations. In the NHS, around 196,000 staff joined or took up new roles between September 2020 and September 2021; in social care approximately 490,000 staff joined or took up new roles in the financial year (FY) 2020 to 2021. The potential for impact is significant, the requirement for scale imperative.

The aim of this programme is to introduce new starters to the culture and values that are expected within services and to foster a sense of belonging wider than the immediate organisation. The content of this programme should therefore be co-created by partners across health and social care, including NHS England, DHSC, Local Government Association, Skills for Care, staff networks and patient representatives. This programme should be for all new entrants including those entering formal programmes (such as the Graduate Management Training Scheme or the Assessed and Supported Year in Employment programme) and be used in combination with local inductions. The framework should be nationally set, with certain allowance for local variation, and made universally available to ensure consistency. There is scope to build on the Care Certificate standards, which already set out the introductory knowledge and skills that are important for those in non-regulated roles.

Mid-career

This programme is targeted at middle managers working in healthcare, social care, local government, and relevant voluntary and private sector organisations. We believe this needs to be 3 to 5 days and in person to get the full benefit, including ideally the creation of local alumni networks. It should work in harmony with the new national leadership programme outlined in the integration white paper. On implementation, the sectors

should work together to identify the cohort for this programme which could include, but is not limited to, GPs, mid-career clinicians, NHS middle managers, principal social workers, registered managers and so on. It is vital that the content is co-created if we are to realise the level of collaboration, system awareness and local delivery needed for the future. Again, the framework content should be nationally set to ensure consistency, with flexible and local delivery, either within ICSs or at place level across regions.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

It is the task of leaders at every level to cultivate the conditions for individuals to overcome entrenched and often unacknowledged disadvantage, by ensuring staff recognise and remove subtle exclusionary practices, and by working to remove the set of unspoken assumptions that favour certain groups in terms of career advancement [see recommendation 5]. Dedicated EDI professionals exist to enable this transition. We would anticipate the numbers of dedicated experts to reduce as they successfully instil such awareness in leadership at all levels.

If implemented effectively, we are hopeful that every one of our recommendations will improve equality opportunity. In addition, we believe the following specific measures are urgently needed to enable the necessary improvements on EDI outcomes across health and social care:

- educate leaders to ensure they understand their role in demonstrating and improving inclusive leadership. This must include a more central role for EDI in leadership training and development which, in turn, requires greater skills and understanding of the topic from those delivering the training. We would encourage the use of the Everyday Discrimination Scale as a useful, objective tool which supports leaders and teams to address this issue in the workplace
- agree and set uniform standards for equal opportunities and fairness across health and social care at entry-level and mid-career level [see

recommendations 1 and 3]. Use accredited training modules to set and maintain these standards [see recommendation 3]. Ensure organisational and individual accountability for delivery against these standards, including through appraisals [see recommendation 4]. Uniform standards should help leaders learn how to address discrimination at individual, team and systemic levels

- more stringently enforce existing measures to improve equal opportunities and fairness across all NHS functions. We would encourage similar universal targets in social care. Teams and organisations should set year-on-year goals for improvement, for example by increasing the representation of under-represented groups in training, in development opportunities, and in senior roles [see recommendation 5]
- to support such accountability, the CQC needs to reinforce the behavioural and cultural change necessary, as recommended in the Inclusive Britain policy paper. This includes ensuring that regulators take account of EDI data as part of their organisational assessments, and particularly the seriousness with which it is viewed by leaders

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

While these recommendations are NHS specific, there is scope for the standards and core content of training and development bundles to be used more widely across health and social care, which should be explored in further detail. There is also good practice within social care from which the NHS can learn, such as principal social worker and registered manager standards.

The implementation next steps are as follows:

- development of the standards – the standards should be co-created, with input from across healthcare, including patient representatives, accounting for good practice that already exists, such as in the NHS People Plan. They should cover operational, strategic management and most importantly, the behavioural components and responsibilities for managers for inclusive leadership, as

underpinned by all parts of this review. Once developed collaboratively, they should be nationally led and accessible to all

- development of the training bundles to meet the standards – single, standalone training intervention is unlikely to deliver the depth and breadth required, so we propose the co-creation of training and development bundles. These bundles should include a number of consistent training modules, on areas such as inclusive leadership [see recommendation 2] and core management skills and tools (such as how to conduct an effective appraisal [see recommendation 4]). This should build on existing good practice, such as the work of Proud2BOps in this area. We believe these bundles need a single accreditation process within the NHS to ensure consistency, high quality and portability. The bundles should also offer choice and flexibility to accommodate profession-specific requirements, local needs and individual career aspirations. Flexible components could include experiential learning, job shadowing, e-learning and skills-based projects
- roll out – in the first instance, the bundles should be made available to non-clinical NHS managers at entry and at a prescribed mid-career point. This will underpin a more established career pathway and professional status for non-clinical managers; we believe that the qualification needs to be transferable, recognised across the NHS, and a pre-requisite for further advancement. Some flexibility will be required for lateral entry. Over time, this should be a mandatory requirement for NHS managers [see recommendation 5]
- expansion – following roll out, there is opportunity to expand these bundles to all NHS clinical and non-clinical managers alike. This necessitates further work with educators, commissioners and regulators to develop the read-across to postgraduate clinical curricula where leadership and management skills are required

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

While appraisals were paused during COVID, all staff in the NHS should have an annual appraisal. However, some express cynicism about effectiveness, as shown in the latest NHS Staff Survey. Improvement is needed to the process and quality of appraisal, irrespective of whether individuals wish to progress to higher roles or not. The new system should be based on improvement methodology in 2 parts:

- performance in role including both technical and behavioural elements
- a career conversation around ambition and aspiration

This should enable individuals, organisations, and the system to clearly identify talented individuals and their development needs; and then link them to the wider system [see recommendation 5].

Commitment to a unified, simplified appraisal process demonstrates a move away from siloed processes, short-termism and the whims or biases of individual leaders and managers. It requires a shift from the current unwarranted variation in how performance and career aspirations are managed, to a process that is equitable and supportive for all – working at the pace of individual aspiration.

All NHS employees should be within scope for this recommendation, but this should start with a focus on non-clinical managers in the 2022 to 2023 financial year to ensure those most in need of structured career management are supported as a first priority.

The new process should assess the extent to which the individual has upheld the core values of the service and the extent to which they demonstrate a commitment to EDI and fair treatment, not just technical skill [see recommendation 2]. It should focus on how the individual has behaved, not just what they have done.

Appraisals will continue to be an annual performance and career conversation, with in-year follow up, based on a single set of documentation, which should be co-created, agreed nationally and made available to all organisations. It should be designed to sit alongside and complement documentation needed for professional revalidation. The new system should have latitude for team input, including more extensive use of 360 feedback where appropriate.

As the effectiveness of appraisal is as much to do with the appraiser as with process, the management bundles [see recommendation 3] include compulsory training for effective, fair and inclusive appraisal. It is necessary that the new appraisal system considers the appraisee’s experience of their manager, in relation to their commitment to EDI and their inclusive practices [see recommendation 2]. Appraisal data, including completion, satisfaction and outcomes, should then form part of the evidence of a well-led organisation within CQC assessments.

5. A new career and talent management function for managers

Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

There is a need to create a more aggregated career management function to address 3 problems:

- the lack of clarity for career progression in management
- the failure of the system to utilise and encourage the diverse talent available [see recommendation 2]
- the shortage of people wanting to be managers in challenged parts of the system [see recommendation 7]

An effective career and talent management function could overcome these challenges, providing a compact between NHS managers and their organisations – both in support of the individual and to the benefit of the organisation and the system. The function should sit predominantly with NHS England at regional level; but forming part of a coordinated structure at organisation, place, system and where necessary national level. It should initially support and provide structure for non-clinical NHS management careers, with the potential to expand the remit rapidly to also cover clinical managers once established.

This needs to be inclusive, with sufficient scope, scale, and authority to perform the following functions:

- plan – give structure to succession planning wider than can be achieved in individual organisations or systems; including moving people with the right skills and experience to where they are needed most [see recommendation 7]
- support – provide individuals with career advice and support; encourage and signpost training and development opportunities; and provide clear routes to promotion for every individual, encouraging breadth of experience [see recommendation 2].
- hold and analyse data – responsibility for data collection and storage of data on all managers, categorised by profession, in each region. Such regional databases would supplement the national database of board level appointments which was recommended in Kark's Review
- manage talent – encourage and manage the talent within a geography to ensure better visibility, effective succession planning, and matching skills to role and need. Discourage talent-hoarding, where it exists

- oversee – oversee compliance with mandated managerial standards, associated training, and appraisals [see recommendations 1, 3 and 4]

6. Effective recruitment and development of non-executive directors (NEDs)

Establishment of an expanded, specialist non-executive talent and appointments team.

All boards have 3 roles: formulating strategy, ensuring accountability and shaping culture. NEDs and board chairs achieve this through bringing independent, external perspectives, skills and challenge. They make up over half of NHS board roles, yet their importance can be undervalued.

In the absence of sufficient central support, NHS organisations and latterly systems repeatedly fund private sector executive search firms at significant cost. Despite this, appointments lack the diversity and wider experience needed for this vital assurance role, sometimes presenting people already known in the system. We must improve this.

The current non-executive talent and appointments team within NHS England is highly regarded, yet too small to achieve the depth and reach needed. An expanded team could undertake a range of new and scaled up activities to support provider and system boards in close partnership with wider NHS England regional teams. These activities could include maximising attraction, setting standards and consistency in role descriptions, role preparation, induction and onboarding, management of talent pipelines and talent pools, central and regional databases and creating networks.

The team should have clear outcome measures and be accountable for evidencing a tangible shift year-on-year in diverse appointments [see recommendation 2]. A report by NHS Confederation shows the gains made in the early 2000s towards board diversity in the NHS have not been sustained, particularly in relation to women, people from black and minority ethnic communities and especially chairs and NEDs with disabilities. From the current position, we must break the mould and ensure a wider cross section of society see themself fulfilling this vital role. In short, the NHS must achieve greater diversity so that NED and chair roles more closely reflect the communities they serve and the staff they govern.

Without greater penetration into other sectors, investment will not result in the change needed nor deliver the pipeline of diverse NEDs that can provide the skills and oversight needed. An intervention based on the roles of the individual, team, organisation and system will best shape the NED contribution in the future. Therefore, forging greater links within systems, with other governmental departments, other public sector organisations and commercial providers is vital.

7. Encouraging top talent into challenged parts of the system

Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

There are currently little or no incentives for leaders and managers to move into leadership roles in organisations in challenging circumstances. This section builds on previous recommendations in Sir Ron Kerr's Review around a 'new deal' for leaders to make improvements through the creation of "an agreed package of incentives and support for leaders that take on 'difficult to recruit to' roles".

While there is good work already in train through NHS Intensive Support Teams, an improved and more widespread offer is needed as leaders have reflected to us that the reputational risk of failure remains too high. The package of support offered to leaders and managers should consist of the following functions:

- build team capability – strategically place talented managers and clinicians into organisations and reward them with upward career progression, as being selected should be role modelled and celebrated [see recommendation 5]. Support new recruits and executive teams with a regional taskforce, which includes experienced clinicians and managers, to co-produce a sustainable improvement plan
- provide holistic support and diversity – provide support networks for executives, clinicians and managers, such as peer mentoring, coaching, training and development, and positive action programmes [see recommendation 5]
- allow time and space for improvement – NHS England, CQC and others to reduce reputational risk and target pressures by bolstering support for leaders, championing progress, and accepting that failure is a normal component of service improvement and transformation, thus allowing leaders the psychological 'freedom to fail'

- ensure pragmatism – develop realistic improvement plans with appropriate structural support. These should be explicit and set out the expectations of the team, resource and support available - including funding to improve the quality of digital, estates, and equipment (as identified in Kerr's Review). The plan should be peer reviewed by provider chief executives to ensure it is pragmatic
- attract top talent – use flexibility in available terms and conditions to attract and deploy talented individuals at Very Senior Manager level, including relocation support where available and appropriate for staff moving to rural and coastal areas where unwarranted variation tends to be greatest

4. Implementation

We strongly believe our recommendations should transform health and social care leadership and management and drive the cultural and structural changes necessary to future-proof it. But we also recognise that previous reviews have reached equally sensible conclusions but failed to have the impact they deserve. To avoid a similar fate, we would highlight the following key components of successful implementation:

- Review Implementation Office (RIO): this group, comprised of multi NHS, social care and local government members, and with the highest agency, is essential to provide and drive the pace and scale of the implementation of this review. Its task is to deliver beyond anything that we have in the system at the moment; and to foster sector-wide co-creation to set achievable deadlines and apportion appropriate responsibility. This group should have direct mandate from the Secretary of State and support from the leadership in NHS and local government to deliver the review's recommendations
- ownership and accountability by example from all leaders: for any recommendation to have a chance of making an impact, the leadership must buy into its provenance and live by its virtues. Indeed, the NHS Leadership Compact – 'Our Leadership Way' could easily be used: it has resulted from deep and wide consultation and aligns with the NHS People Plan and People Promise. We get a strong impression from the new leadership at the top of the NHS and from local government that this is an agenda they are prepared to own, incentivise and live by. But buy-in and co-creation from those most affected is also key, and we would encourage a collaborative approach to implementation, drawing on experience and insight from

all leaders and the workforces they lead. There should be a strong local, frontline representation, and service users must be incorporated

- allocated time and resource: while we recognise the continuous pressure that the system will remain under, we strongly recommend a re-balancing of time and resource towards supporting and developing the workforce and argue that this will quickly repay the investment in the form of greater productivity, efficiency and quality
- data to support decision-making: workforce data is not yet sufficiently mature to support rapid implementation of some of our findings. While service-user data initiatives are clearly the priority for the time being, we would encourage resource being available to deliver the data necessary to facilitate workforce planning and support
- firm policy on participation: we believe our recommended training and development elements should be mandatory for selected cohorts. Making participation optional will effectively de-prioritise it and, while sensible flexibility will be necessary especially in the primary care and social care arenas, we would advise a firm policy on participation
- associated rationalisation: a common symptom of change in hard-pressed organisations is that new initiatives are bolted on to, rather than merged into, existing frameworks. This only adds to complexity and inefficiency and inevitably lessens impact. There is certainly scope for rationalisation in the current approach, and we would encourage a root and branch re-alignment of leadership and management development as part of the ongoing re-organisation, with as much integration between health and social care as is organisationally feasible

We recognise that change cannot happen overnight, and that resources and staff effort are necessary pre-requisites to reform programmes. To that end, we have offered the Department and NHSE a number of recommendations for a resourced FY 2022 to 2023 programme to set the conditions for a fully-funded and supported programme of leadership and management investment programme in FY 2023 to 2024. This includes the formation of multi-disciplinary implementation teams and a number of proposals for early wins.

5. Acknowledgments

The review team was made up of a plethora of health and social care sector subject matter experts, who were a great source of knowledge and guidance:

- Daniel Acheampong
- Fred Atkinson
- Samina Aziz
- Anna Boaden
- Mike Haslam
- Dr Joe Home
- Mark Hutchinson
- Tracie Jolliff
- Gavin Larner
- Sir Gordon Messenger
- William Monaghan
- Shareen Pavaday
- Rachael Phillips
- Dame Linda Pollard
- Dr Clare Price-Dowd
- Prof. Wendy Reid
- Prof. Laura Serrant OBE
- Prof. Andrew St George
- Amber Taylor
- Hannah Wingfield

The review team met with many hundreds of incredibly passionate, devoted and hardworking individuals from across many different levels of health and social care. Thank you to each and every person, group and organisation who took the time to engage with the review team; your insights were invaluable in shaping this report.

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in mind caused by this blurring or this confusion, as you have described it?

A. If there is an operational performance issue, such as, to take for an example, dictating of patient notes, as an example, it could happen anywhere and it does happen occasionally there are issues around that. On one level that's a very straightforward, you know you need to get a dictaphone or a recorder. You need to sit down and report. It's a very simple process issue that is managed within the Directorate, and the Clinical Director can manage at an operational level. It seems at one level to be very straightforward. When it becomes a persistent problem then it starts really to become a professional issue. There can be confusion then over who deals with that, and this is one of the problems I think we have with our current Health Service management systems. To give you an example where I think things worked better, and this is just my personal opinion. In the days when I was Clinical Director in Radiology, the Clinical Director of the Department would have been the budget-holder in the Department and was Head of the Department and was responsible for everything within that. They would have clinical standards. They carried the can for the budget, for the staffing levels, everything. It was very clear who was in charge and who to go to if there was a problem. We have a system now where that is not so clear. The Clinical Directors are no longer the budget-holders. I'm not sure they are not sorry they

10:47 10:48 10:48 10:48 10:49

are not, but they are not. There are two management structures, if you like, there is a clinical line and there's a management line. Sometimes people become confused as to which is the right direction to report issues to, and the managers themselves are confused as to who should deal with them. The system can work really well. We have got people who are well trained and they have time to consider their actions, and they have good relationships between teams, and that's great and it often does work really well. But where relationships are not so good and the clinicians and the individuals are very busy and under a lot of stress, that system cannot function as well. My personal view is, the dual line can be confusing on occasions and isn't helpful in this type of situation because, in reality, there is a blur between professional and operational matters. 10:49 10:49 10:50 10:50

86 Q. I'm not going to bring you to it now but just for the panel's note, you deal with this in a number of places in your statement, and, in particular, WIT-17895. I think you have said one solution would be to have a medically qualified person in sole charge to make the reporting lines clear and simple. Is that, I suppose back to the start of your career? 10:50

A. That would probably be a very unpopular thing to say but, in many circumstances, I think that would be clearer. But the key thing is the person is appropriately qualified and has appropriate capabilities. That's probably more important than

A. I think one has to be pragmatic in that we had the director of the service and the Associate Medical Director and the Clinical Director responsible for the service who were taking a particular tack. There's only so much one can do to impose one's will. It never had arisen before. So I was convinced that it was worth letting the plan run to see if it would be it of some benefit. I clearly was frustrated by the process. I did agree to a change of tack, which we subsequently reversed, and I wasn't have surprised when we had to reverse it, ultimately. 16:15 16:16

256 Q. Can I just ask a couple of other things. I'm just going back over to my notes now.

Yes, I suppose there were -- we've heard about blurring of responsibilities and how that contributed to the slow pace of getting to grips with the issue. Would you consider that by agreeing to go along this path that was presented by Mrs. Gishkori to you, that again was blurring the responsibilities? 16:16 16:17

A. I'm not sure. I think I was being pragmatic in that it was the only game in town, really, that was likely to work at that point. I was under no illusion that we may have to reconsider that approach if it didn't work fairly quickly. I think there is a tension between delivering a clinical service and maintaining high safety and quality standards. That is something that every director has to grapple with. And I think in this particular instance we were slow to appreciate 16:17

Southern Health and Social Care Trust

Quality Care - for you, with you

Medical Leadership Review

2018

V-11 - 10th September 2018

Dr Ahmed Khan

DRAFT



Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

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Section 1 – Medical Leadership Structure Review Framework

1. Background and Context

- Good medical leadership has been identified as vital in delivering high-quality healthcare[1]. There is an increasing body of published literature that links the performance of units to levels of medical leadership[2].

- To achieve strong medical leadership competence doctors are required to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which modern health and social care is delivered[3].

- The medical leadership structure within the SHSCT last underwent a review in 2011 where medical leader's functions, responsibilities and accountabilities were considered. Additional leadership roles were introduced to support medical revalidation processes, GMC responsible officer requirements and to support the development of SAS grade doctors.

- Given the length of time since this review and the significant changes in health and social care landscape it is time to review and possibly to revise, the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a highly dynamic environment.

- The structure that emerges from the review must have the appropriate processes and resources to support the effective delivery of high quality, safe, patient focussed services, and to support education and research. It must ensure appropriate ongoing scrutiny of the clinical performance of existing services, as well as new developments.

- It must facilitate timely, transparent decision making to maximise opportunities to improve existing services, and where appropriate, develop new services for patients. It

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[1] *Warren OJ, Carnall R Medical leadership: why it's important, what is required, and how we develop it Postgraduate Medical Journal 2011;87:27-32.*
[2] *Clark J. Enhancing medical engagement in leadership. InView 2006;10:14e15.*
[3] *Darzi A. A time for revolutions – the role of clinicians in health care reform. N Engl J Med. 2009;361(6):e8.*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

must encourage all clinicians contribute to the development of the Trust strategic planning and then take responsibility for contributing to its delivery.

2. Strategic Drivers

- The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental[4].

- The leadership task is to ensure direction, alignment and commitment within teams and organisations Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work.

- Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[5].

2.1– HSC Collective Leadership Strategy

- Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

2.2United Kingdom Regional Workforce Strategy Policy Direction

- All NHS UK regional Departments of Heath have endorsed leadership models that suggest clinicians need to become more actively involved in the planning, delivery and transformation of health and social care services[6,7,8,9.]

[4] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*
[5] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

- Current NHS Workforce Strategies are based on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

- Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

  - ***Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services***
    "*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

  - ***Department of Health England, Next Stage Review: High Quality Care for All***
    "Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

  - ***NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership***
    "Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

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[6] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*
[7] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*
[8] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*
[9] *National Leadership and Innovation Agency for Healthcare Wales*
1 HSC-*Collective Leadership strategy*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

- ***National Leadership and Innovation Agency for Healthcare Wales***
  "Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. Why Invest In Medical Leadership

- Clinicians across Health and Social Care are often be asked to take on leadership roles, with responsibility for staff objectives, appraisal, and performance management, as well as all other resource management issues, without supports to help them make the necessary transformation into these roles.[10].

- Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

3.1 The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[11]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[12]

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[10] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[11] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[12] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[13]
- A study in the Harvard Business Review (*Bassi and McMurrer*) provides a strong link between leadership skills and organisational performance[14]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[15]

4. Review of Best Practice Literature

4.1 NHS Medical Leadership Competency Framework (MLCF)

- The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

- The MLCF describes leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice, Tomorrow's Doctors and also Management for Doctors.

- While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services.

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[13] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*
[14] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[15] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

- Doctors also have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. The development of leadership competence needs to be an integral part of a doctor's training and learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

- The Medical Leadership Competency Framework (MLCF) is built on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

4.2 Clinical Leadership Competency Framework (CLCF)

- The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

- The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

- Clinicians have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

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4.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

- The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring: the team has articulated a clear and inspiring vision of the team's work; there is clarity about the team's membership; team members agree five or six clear, challenging, measureable team objectives; there is strong commitment to collaborative cross-team and cross-boundary working.

- The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

- Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

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5. Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trusts most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[16] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each service area

[16] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

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Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

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6- Review Process timeline

6.1- Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

6.2- The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[17] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	30th July 2018
3	**Development of a Proposal Paper for SMT Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	30th October 2018
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Jan 2019

[17] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

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7. Current Trust Medical Leadership Structure

7.1- Medical Leadership Structure (since 2011)

- The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

- The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the consolidation and discontinuation of two AMD positions:

    - **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
    - **AMD Infection Prevention and Control – *Post not retained (2015)***

7.2- The current Southern Trust Medical Leadership Structure is outlined below:

Medical Leadership Structure Today (June 2018)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care (Aligned to OPPC)
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *4 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*

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AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair & Sub-speciality chairs
CAH Medicine Chair* & Sub-speciality chairs
Trust wide Surgery Chair* & Sub-speciality chairs
Trust wide CYPS Chair
Trust wide IMWH Chair
Trust wide MHLD Chair

* *Medicine and Surgical Specialities are supported*

8. The Case for Change

- Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

8.1 Supporting and Influencing Service Planning

- Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.

- Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes.

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Doctors are uniquely positioned to understand the potential impact of policy or funding changes[18].

8.2 Providing a Link from Ward to Board

- Medical leaders understand the complexity of modern health care services and understand both how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[19].

8.3 Performance of Frontline Teams

- There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

[18] *Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.*
[19] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

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9 Consultation with Trust Medical Leadership

- As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model. A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix.
- A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

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- The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

- Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

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10. Consultation with Trust Directors

10.1 Trust Directors were asked to give their views and opinions on current medical leadership structure. A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role.

10.2 A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

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Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

10.3 The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

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11. Comparison with Analogous Organisations

11.1 - Northern Ireland Regional Trusts

- The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust
• Medical Director • Deputy Medical Director • AMDs • Clinical Director Structure*	• Medical Director • Deputy Medical directors • AMDs • Clinical Director Structure*
Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director • Clinical Director Structure* • Lead Clinicians	• Medical Director • Deputy Medical Directors x3 (5PA each post) • Divisional Director leads • Clinical Director Structure* • Lead Clinicians**

** Lead clinicians are formal roles within the medical leadership structure

11.2 NHS United Kingdom Acute Trust Models

11 The following comparison is of two NHS UK Trusts who have published their medical leadership structures, it is important to note that terminology of medical leadership role titles is often unstandardized and responsibilities can vary widely.

Mid Cheshire NHS Foundation Trust	Warrington and Halton Hospitals
• Medical Director • 1 DMD • Clinical Director Structure* • 1 Patient Safety lead • 1 Clinical effectiveness lead •	• 1 MD • 1DMD (8 PAs) • Clinical Director Structure* • Lead Clinicians**

*Clinical Directors are equivalent of SHSCT AMD roles

**Lead clinicians are formal roles within the medical leadership structure

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Section 2 – Proposed Medical Leadership Structure

12. Medical Leadership Development and Competence

12.1 The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's) and Infection Prevention and Control (2 PA's) were stood down and the duties merged into operational AMD roles.

12.2 To further integrate the role of Associate Medical Directors and Clinical Directors with the Medical Director it is proposed that one third of the cost of operational AMD and CD PA role cost is funded from the Medical Directors budget (the remaining two-thirds met from existing operational directorate funds). The revised PA funding allocation will allow a portion of medical leadership responsibilities to be aligned to the medical director formally.

12.3 A supplementary paper titled ***"Medical Management and Leadership Development Program"*** will follow.

13. Medical Leadership Fixed Term Appointments

13.1 This paper proposes that all senior medical leadership positions commencing from January 2019 are fixed-term appointments (details found in subdivision 13 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

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14. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

14.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services, support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	10PA
Areas of Responsibility	• Medical Professional Governance including RO duties, • Clinical and Social Care Governance, • Medical Workforce Development, • Medical Education & Training • Audit & Research with Linked to QI,

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	• Infection Prevention and Control • Emergency Planning
Appointment Term	Permanent Post

14.2 Deputy Medical Directors (2 part time Posts Total)

Role Description	**DMD – Workforce Development (New part time post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	5 PA (To be funded from proposed new MD budget)
Areas of Responsibility	• Medical Appraisal & Revalidation • Job Planning • Medical Professional Governance • Litigation Oversight
Appointment Term	5 years Initially – with 1 year extension if required

Role Description	**DMD- Safety and Quality (New part time post)** The Deputy Medical Director (Safety and Qualit) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality Lead • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Quality Improvement

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	• Clinical Audit
PA Allocation	5 PA (To be funded from proposed new MD budget)
Appointment Term	5 years Initially with 1 year extension if required

14.3- Associate Medical Directors (10 Posts Total)

Role Description	**Associate Medical Directors (Operational Services)**
Number of Posts	8 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine and Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services • A/E (Currently included in Medicine & unscheduled care)
PA Allocation	3 PA per post (1 PA funded from proposed new MD budget, 2 PA's from Operational Budget)
Appointment Term	4 Years Initially with 1 Year extension if required

Role Description	**Associate Medical Directors (Corporate Services)** Associate Medical Directors with professional and corporate responsibility for Medical Education and Research and Development.
Number of Posts	2 Posts (All existing fully funded)
Areas of Responsibility	• Medical Education & Training • Research and Development
PA Allocation	3 PA per post (funded from MD budget)
Appointment Term	4 Years Initially with 1 Year extension if required

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14.4 Clinical Directors (22 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for
Number of Posts	22 Posts (All existing funded for 1PA)
Areas of Responsibility	Assigned as per existing AMD Structure
PA Allocation	1.5 PA per post (0.5 PA funded from proposed new MD budget, 1 PA from Operational Budget)
Appointment Term	3 Years Initially with 1 Year extension if required

14.5 Lead Clinicians

Role Description	**Lead Clinicians (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Assigned as identified by operational directorates
PA Allocation	PA cost to be agreed and funded by responsible operational directorate (proposed 0.25 -0.5PA)
Appointment Term	2 Years Initially with 1 Year extension if required

14.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts

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Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Deputise for Responsible Officer for signing-off revalidation paperwork • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning,

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	• Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.8 Morbidity and Mortality Chairpersons

Role Description	**Morbidity and Mortality Chairs (Per speciality basis, as identified by Operational management)** A separate paper has been developed for Morbidity and mortality. M&M chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework • Determine, support and develop appropriate patient safety inputs to the meeting • Monitor the appropriate attendance by all relevant disciplines and professional groups • Monitoring timely completion of screening templates • Monitoring of medical staff participation in Case Presentation
Number of Posts	6 Posts (existing funded) + 4 subspecialty
Areas of Responsibility	• DHH Medicine Chair • CAH Medicine Chair • Trustwide Surgery Chair

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	• Trustwide CYPS Chair • Trustwide IMWH Chair • Trustwide MHLD Chair • Sub speciality Chairs
PA Allocation	1-1.5 PA per post (depend on workload (1PA currently funded)
Appointment Term	3 Years Initially

14.9 Clinical Governance Leads and Quality Improvement Leads

- Each directorate will have the opportunity to develop Clinical Governance Lead and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

14.10 Administrative and Clerical Support Requirements

- To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Role	Time Allocation	Supporting Band
Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Associate Medical Director Support	6 hours per AMD per week (10 posts)	1.5 WTE Band 3
Clinical Director Support	1.5 hour per CD per week (22 posts)	1.5 WTE Band 3
Lead Clinician & M&M leads Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

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15. Proposal Costings

15.1 To support this arrangement a budget for medical leadership that is the responsibility of the medical director will be required to be established in Medical Directorate.

15.2 The proposed costing for new model would be based on:

	Proposed New Medical Director Budget (Allocation Per Post)	Operational Directorate Budget (Allocation Per Post)
Associate Medical Director (3 PA) Per Post	1 PA	2 PA
Clinical Director (1.5 PA) Per Post	0.5 PA	1 PA

15.3 The following costings for the revised medical leadership structure are as follows.

	Currently Funded	New / Additional Funding Required
Medical Director	10PA	0PA
Deputy Medical Director – part time (Workforce Development)	New Post	5PA
Deputy Medical Director – part time (Safety and Quality)	New Post	5PA
Associate Medical Directors (Operational)	24PA	0PA
Associate Medical Directors (Corporate)	8 PA	0PA
Appraisal and Revalidation Corporate and Consultant Leads	2PA	0PA
Appraisal and Revalidation SAS Lead	1PA	1PA
Clinical Directors	22PA	11PA
M&M Chairs & subspecialty chairs	6PA	3PA*

**3 PA's for M&M chairs are to formalise support for sub speciality M&M meetings in Medicine and Surgery specialities*

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2 The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1 WTE Band 4)	0 WTE	1 WTE
Associate Medical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE
Clinical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE

**Please note this is rough estimate only*

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16. Proposed Service Enhancements and Accountabilities

16.1 Service Enhancements (Measurable Outcomes)

- Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

- At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline processes and outputs	• Responsibility for providing assurance on Trust Standard and Guideline processes and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust

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	• Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Lessons Learned functions	• Responsibility for the oversight and implementation of the Trust Lessons Learned function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff feedback. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Lessons Learned processes
Strengthened support for Trust Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety

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	improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

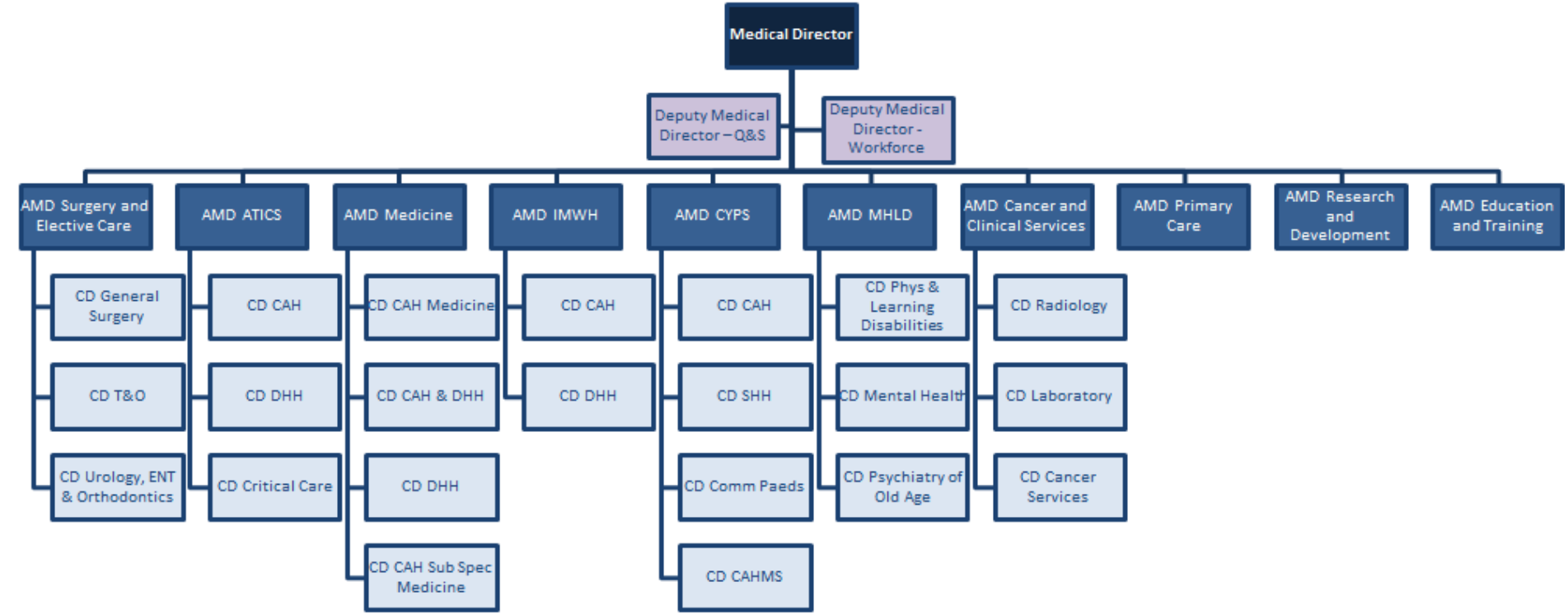
16.2 Integration with Operational Management Roles

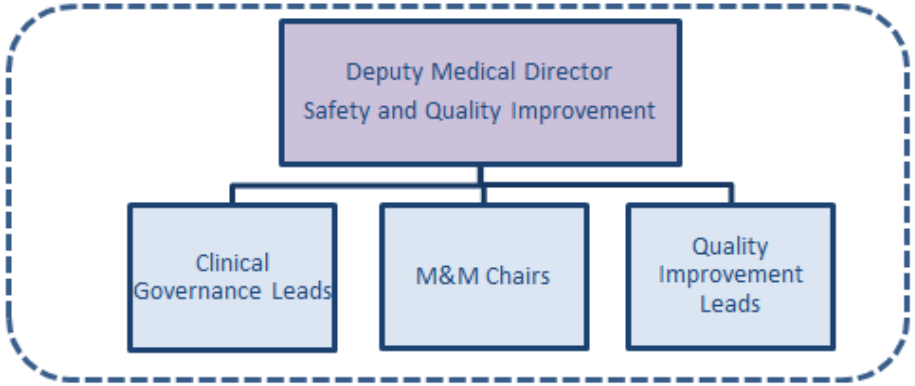
- It is proposed the following initial formal interfaces will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

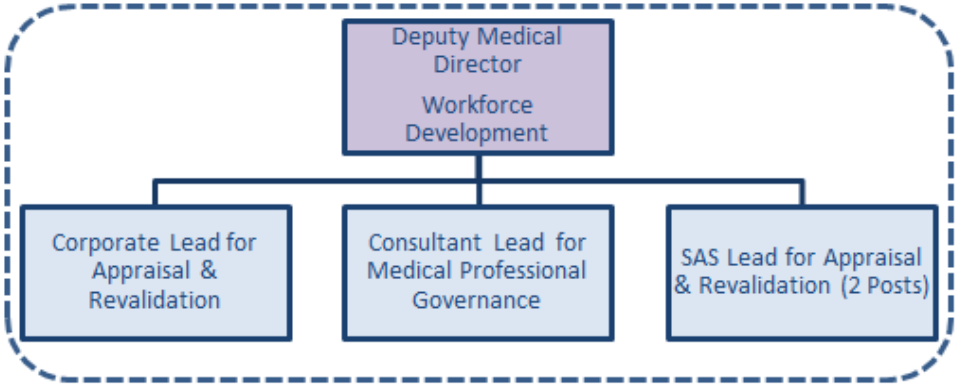
Type of Interface	Name	Composition
Corporate Interfaces	Senior Leaders Forum	Trust Directors, AMDs and CDs (Quarterly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Interfaces	Directorate Governance Meetings	Directorate SMT Meetings (Monthly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

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Appendix 1 – Proposed Revised Medical Leadership Structure







Appendix 2 – Consultation with Trust Medical Leadership

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Appendix 3 –Consultation with Trust Directors

1) How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

2) How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Also covered by my suggestion for Question 2 point 2

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- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Calrity re role and responsibility for medical leaders vs operational managers, need clear guidance
- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

3) Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD (now off) took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A lessons learned MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas

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- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.
- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

4) Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

5.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

19. The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring:
    - The team has articulated a clear and inspiring vision of the team's work
    - There is clarity about the team's membership
    - Team members agree five or six clear, challenging, measureable team objectives
    - There is strong commitment to collaborative cross-team and cross-boundary working

20. The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

21. Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

6. Current Trust Medical Leadership Structure

6.1 Medical Leadership Structure (since 2011)

22. The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

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23. The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the discontinuation of three AMD positions, the rationale for this is unclear:

- **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
- **AMD Infection Prevention and Control – *Post not retained (2015)***
- **AMD Standard and Guidelines – *Post not retained (2015)***

24. The current Southern Trust Medical Leadership Structure is outlined below

Medical Leadership Structure Today (May 2019)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *3 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*
AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair

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CAH Medicine Chair*
Trustwide Surgery Chair*
Trustwide CYPS Chair
Trustwide IMWH Chair
Trustwide MHLD Chair

* *Medicine and Surgical Specialities are supported*

7. The Case for Change

25. Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

7.1 Performance of Frontline Teams

26. There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

7.2 Providing a Link from Bed to Board

27. Medical leaders understand the complexity of modern health care services and how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[23].

[23] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

A. So I obviously do go on ahead and take it further and I'm sure Mr. Mackle knew at the same time. But within the hierarchy, and certainly at that time, I didn't feel I could go outside of those two lines, so in the course of asking myself, should I have gone directly to the Medical Director myself, should I have gone to the Chief Executive myself, but that's good in hindsight but then you stayed within the relation lines. 16:03

417 Q. Yes. It's perhaps a convenient example upon which to ask you about your reflections or your impressions of the effectiveness of the medical/operational management split and whether it had the potential to have, I suppose, gaps within it when the focus of both sides of management should be on Patient Safety, mitigating risk and delivering an effective service. Does that illustrate perhaps a gap you can't -- well, you can take it further, but if medical management are not going to push it, you have got to spend time taking it further, and then I think it was February before Mrs. Burns is able to come up with a solution with Mr. O'Brien which involved him only taking named referrals? 16:03 16:04 16:04

A. I know we are looking at an issue that didn't work out and there were many issues where operational and professional management worked very well together to come to very good solutions, but I think in this particular issue that was maybe much more difficult and more challenging. It didn't work as effectively obviously as it could have or should have done. 16:04

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Description

JOB TITLE Medical Director

INITIAL LOCATION Trust Headquarters, Craigavon Area Hospital

REPORTS TO Chief Executive

ACCOUNTABLE TO Chief Executive

JOB SUMMARY

The Medical Director is an Executive Director and member of Trust Board. The postholder will advise the Trust Board and Chief Executive on all issues relating to professional Medical workforce, clinical practice and quality and safety outcomes.

The postholder is the Trust's nominated Responsible Officer and will also carry lead Director responsibility in a number of organisationally critical areas including Health Care Acquired Infection (HCAI), Research & Development and Emergency Planning.

As a member of the Trust Board and the senior management team he/she will inform and shape Trust strategies, support the communication and consultation on such strategies, share corporate responsibility for the achievement of the Trust's corporate objectives and for driving forward a culture of change, innovation, development and modernisation.

KEY RESULT AREAS

GOVERNANCE

1. To lead in the development of a framework to ensure a strong infrastructure of medical leadership within the Trust, including the development of a competency framework to drive succession planning.

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2. Provide professional leadership and guidance to support Associate Medical Directors (AMD's), Clinical Directors (CD's) and Lead Clinicians throughout the Trust in relation to governance of the medical workforce including clinical practice and service change.

3. Work with other Directors to inform, support and provide assurance on the systems for the effective identification and management of clinical governance concerns, ensuring that any learning is incorporated into professional practice and systems.

4. As a member of the Senior Management Team and Trust Board, the Medical Director has corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.

5. As the designated Responsible Officer for the Trust, the postholder will have responsibility and accountability for the following key areas;

a) The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.

b) The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).

c) The designated Trust officer for referring concerns about a medical practitioner to the General Medical Council.

d) Providing professional advice to SMT as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of SMT Governance, to regularly review this information, and to provide assurance or expert input into necessary steps to address any issues arising from same.

e) Providing regular 'Responsible Officer' reports on the medical workforce to SMT, Governance Committee and Trust Board

6. Designated lead Director for strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum and other regional Fora.

7. While the operational responsibility and accountability for patient safety rests with operational Directors, the postholder will be responsible for;

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

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

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

8. Professional lead in relation to Information Governance, specifically the Trust's nominated Caldicott Guardian, and chair of Trust Information Governance Committee.

SERVICE DELIVERY

9. Strategic management and co-ordination of effective Emergency planning within the Trust, including Pandemic Planning.

10. Responsible for ensuring a Major incident policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.

11. Responsibility for Controls Assurance Standards (CAS) for Emergency Planning and Research Governance with provision of Annual Reports to Trust Board.

12. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.

13. Responsible for the strategic management of the clinical aspects of HCAI and Infection Control within the Trust, including the line management of the Infection Control Team and responsibility for CAS for infection control and provision of Infection Prevention and Control Annual Report to Trust Board. The postholder will liaise as appropriate with the Director of Acute Services who is responsible for environmental hygiene.

14. Develop and implement health surveillance methodologies for the Trust.

15. Responsible to Trust Board for the discharge of medical statutory functions.

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LITIGATION

16. To provide medical leadership advise to the Director of Human Resources & Organisational Development in respect of medical litigation including effective integration with wider clinical governance systems and engagement and involvement of other Directorates.

17. Lead Director for the Trust's Medical Negligence and other related committees to:

    a) provide an investigation and management service on behalf of the Trust in relation to claims of litigation in respect of clinical negligence and associated matters

    b) assist HM Coroner with enquiries and the preparation of statements prior to inquests

    c) liaise with the HSCB and/or the Department of Health as necessary for follow up action subsequent to sudden death or significant adverse incidents.

18. Lead decision-maker for management of medical negligence. Provision of regular reports to SMT, Governance Committee and Trust Board to provide assurance of effectiveness of Litigation function, systems and processes.

MEDICAL EDUCATION, & TRAINING

19. The postholder will be responsible for the quality of medical education and training within the Trust working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.

20. Lead on the post graduate training of junior doctors in training within SHSCT, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.

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21. Lead on the work related to the newly established “Sub Deanery” for Queens University (QUB) Medical School within SHSCT, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed with SHSCT. This work includes an Annual report and financial report on the funding provided to SHSCT by QUB in respect of the work of the sub-deanery.

22. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.

23. Responsible for the development and maintenance of professional standards and education liaising with professional and education bodies as necessary.

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

25. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC’s guidance ’Duties of a Doctor’, ‘Good Medical Practice’ and related documents, and succeeding and replacement documents or the GDC’s lifelong learning requirements.

26. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

RESEARCH & DEVELOPMENT

27. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the AMD for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.

28. Responsible for the Trust’s Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

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QUALITY

29. Promote the highest possible standard of medical practice, advice and support to ensure the development of a quality culture with an emphasis on the need for continuous improvement.

30. Promote quality initiatives such as Investors in People and Charter Standards in the Trust and support the development and delivery of a Trust Quality Improvement Framework.

31. Ensure that medical standards are clear and defined in contracts/service level agreements for the provision of services to other Trusts or with independent service providers.

32. Continue to develop and maintain appropriate Quality Indicators, including a comprehensive Mortality Report and provide information and assurance on the intelligence from such indicators to operational Directors, Chief Executive and Trust Board.

33. To ensure that the Mortality and Morbidity process within the Trust underpin and quality assure the mortality indicators and other indicators of quality and opportunities for learning and improvement.

34. Keep up to date with policies and guidelines on good practice from the Royal Colleges, GMC, universities etc. and identify opportunities to enhance the quality of services provided by the Trust.

FINANCIAL AND RESOURCE MANAGEMENT

35. Responsible for the management of the directorate's revenue budget and ensure the meeting of all financial targets.

36. Participate in contract and service level negotiations with commissioners.

37. Advise and assist in the development of capital investment strategies across the Trust, ensuring these reflect and contribute to meeting targets set by the HSCB and the Trust's Corporate Plan.

CORPORATE MANAGEMENT

38. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.

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39. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

40. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

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

42. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

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

44. Ensure appropriate risk management arrangements are in place to deliver safe medical services to patients and minimise the potential for actions against the Trust.

45. Participate in the assurance that an effective system of clinical risk management and adverse event reporting is in place.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

46. Ensure the development of strong medical leadership in the Trust.

47. Oversee, and participate in the arrangements for consultant and associate grade appraisals.

48. Participate in arrangements for recognition of clinical excellence including providing advice on nominations and citations for Distinction and Meritorious Service awards.

49. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.

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50. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff, and ensuring that adequate mechanisms are in place for the welfare of medical staff.

51. Provide advice and guidance on medical workforce policy driving forward a culture of change, innovation and development and modernisation of services.

52. Responsible, in association with HROD for the management of disciplinary matters and complaints relating to medical staff.

53. Review individually, at least annually, the performance of immediately managed staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

54. Maintain staff relationships and morale amongst staff.

55. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

56. Participate, as required, in the selection and appointment of Trust staff in accordance with procedures laid down by the Trust.

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

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

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

59. Actively promote the development of an emergency management strategy with the Directorate to ensure a state of preparedness to respond to a range of internal and external emergency situations.

GENERAL REQUIREMENTS

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

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61. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

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

63. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are responsible to the Chief Executive for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

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

65. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

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

67. To understand this Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

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

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the clinician concerned?

A. Yes. It's very challenging. Most of the people involved in these investigations are -- you know, this is not the only part of their job. They have other clinical challenges, many of them. So getting them all together at critical times is always challenging. The frustration that's felt with the slow progress of these is widespread throughout the organisation, and by me as much as by the individuals directly affected by it. So, yes is the answer. 12:43

111 Q. Again, taking into account that this Inquiry has to reflect and maybe make recommendations around this, have you any thoughts about that? Is there a need to streamline the process? Is there a need to -- I don't mean that you're not professional -- but a greater need to professionalize the process in the sense of making it somebody's specific responsibility? 12:43

A. Yes. I could share you a few thoughts on that. I mean, I mentioned before that for the individuals the Case Managers and case investigators have protected time in their jobs to do this, being expert enough to have received appropriate training to be appropriately resourced with administrative support, and HR support at the times they need it are all challenges within the health service at the minute. If that was improved, that would help a lot. 12:44 12:44

From my own office, at that point the Medical Director's office was essentially composed of myself

and, in relation to these matters, Mr. Gibson. It was very underresourced to provide this. I had highlighted this issue before I left the Trust with a paper to try and bring forward appointments of more staff to help with this, in particular, with Deputy Medical Director posts, one of whom would have a specific focus on this area. But it wasn't possible for that to be supported at the time for financial reasons. So, yes, absolutely. You were trying to do this on top of an incredibly busy and challenging job. At that time I seem to recall we had a -- I'm not making excuses for myself, I'm just painting the context in which this is being done -- we had a major issue with the Emergency Department in Daisy Hill Hospital which was having to be completely restructured and was at crisis level. There was a crisis in the breast care surgery system where we had to get a regional approach pulled together to try to ensure patients were not left wanting in the Southern Trust. There were so many issues going on. This was a relevantly small part of the Medical Director's job and, to be honest, did not have the manpower, the time, required to focus on this. But I think the main issue that would have made a difference would be protected time, training and admin support for the case managers and the case investigators, because they are the ones actually carrying out the investigation. It would have been helpful for me to have had a bit more support but, to be honest, I think the bit that would really make the

12:44 12:45 12:45 12:45

have more time removed from their clinical work. That was a major challenge. For instance, when I was in Belfast Trust as an AMD it was a 50% job. It was a bigger Trust, but nevertheless, whereas it was unusual for AMDs to have more than one or two PAs assigned to their job plan. 15:49

224 Q. Did you set out -- was your vision to try and help doctors understand why they needed to lead and manage in a more modern way?

A. Yes, that would be my own personal professional life. I think one of the most rewarding things about medical management is your ability to develop new services or to modernise or to improve at a level beyond your own individual clinical practice. I think that's the healthiest way for people to get into this side of things. We wanted to develop medical management as a role that people would aspire to as opposed to be forced into. Over the 20 years or so that I was involved in that there was a great move towards that, but still, I think, there is a big issue about recruiting good, capable people into roles like this because of how it drains them physically and emotionally and how underresourced it is. 15:49 15:50

225 Q. Your recommendation on that would be? How do we get over this? 15:50

A. There has to be realistic investment into the medical manpower in terms of the financial side of it, availability of resource to give reasonable numbers of PAs to do these jobs. But it's not just about the

money, it is about seeing how they are valued and their views expressed.

I do think there was a bit of a culture within the Southern Trust, as in the health service in Northern Ireland generally of keeping doctors out of positions where they could actually take decisions. That's my personal view. I think that's been unhelpful and we need to get a more mature view where they can feel engaged. I think that is beginning to happen. I know there have been a lot of changes within Southern after I left, as well. 15:51

The other extreme would be something like the States where some people train jointly in medical leadership and management as in medicine right from the outset as a career path. We're not quite there yet, but there are some things we are doing around the adept fellows, which have been very encouraging and rewarding in giving junior doctors experience of management and leadership roles at an early stage. 15:51

226 Q. There's a lot to do. I would agree.

The route into that will be, I think, through the Medical Directors and medical professionals responsibility for clinical risk, Patient Safety and quality. I think that's the toughest part of the Board position because there's so much to that. There are a lot of safety and quality issues that have emerged as 15:51

a result of this Inquiry. The most striking thing is people didn't realise the extent of the risk soon enough, or in enough detail and this has raised questions about the mechanisms by which assurance is provided or sought and the level of inquiry that's going on. You must have a perspective on that as Medical Director because I'm sure you would agree it's not enough to be told by a Clinical Director that doctor is a good doctor; that objective evidence was needed. What was your plan in terms of your role, in terms of improving on that? Do you think that need was realised at the time or is it, indeed, realised now even? 15:52 15:52

A. I think there would have to be the ability and the capacity to be much more proactive about seeking assurance. That requires manpower, training and expertise. And expertise not just on measuring data off a number of files lying in a cupboard but expertise in human factors training, root cause analysis, some of these analytical tools that have been shown to be so valuable but where the skill base is very weak, certainly in this part of the world. 15:53 15:53

227 Q. Did you recognise that that was a deficit?

A. Yes.

228 Q. Did you raise that with the Board at all? Were the Board aware this was an issue? 15:53

A. I raised it in terms of not specifically in that respect. I certainly raised the need to bolster the resource within the Medical Director's team for seeking

assurances in different ways. Not totally successful -- well not successfully at all, to be honest with you. Maybe that's a reflection of the way I raised the issue. I think the Board were aware of the challenges that there were. I think, to be honest, 15:54
we were hampered, particularly in the Southern Trust, by the multiple changes at senior levels which seemed to be endless and it never allowed any individual the opportunity or the time to make their mark on the system. I think that has been an ongoing issue for 15:54
some time.

229 Q. I think they recognise the need for governance improvements but really as Medical Director it must be uncomfortable to know you haven't got enough assurance, for example, cancer standards, you get 31 and 62 days, 15:54
did you know that the peer review standards were not being met to that extent in urology? I expect you didn't.

A. We would have had quite good data on regard to the simple figures on waiting times, but the detailed 15:55
analysis was lacking.

230 Q. The Board didn't get a regular update on standards in that way, did it?

A. They would have got governance reports on a regular basis through the governance subcommittee. 15:55

231 Q. Would that include compliance with peer reviews or compliance with obstetric reviews, whatever?

A. It partly did but not systematically enough, I think. There would have been various ways of external

monitoring of our quality. We had a quality report that was produced annually and it would be ongoing updating during the course of the year. We would have participated in peer review groups such as, you know, the top 40 CHKS-type system which measured quality indicators. So that would have been brought to the Trust Board but not as systematically or regularly as we required, really, to have an in-depth understanding of the issues. 15:55

232 Q. Job planning has been mentioned by quite a few people. I've looked at quite a lot of the information. It doesn't seem to me that the Trust job planning process included, as mandated, team objectives and individual objectives, and any kind of capacity information built in. Is that correct? Or was that a place where that happened? 15:55 15:56

A. I think that is largely correct.

233 Q. Why was that then?

A. Well, I think it was one of the things that had been allowed to slip. We had a quite highly developed electronic system for the application of job planning. 15:56

234 Q. I've seen it. I've had to use it.

A. I'm not sure it was that helpful, really, because it did away with some of the face-to-face interactions where you can have a more meaningful discussion around that. There was a review of job planning just before I left. We were doing a lot of work around that at the time. We had a job planning task force looking at various different ways to improve the process and to 15:56

improve the outcomes from it. That was still ongoing as I left. We had had a specific issue within Surgery, actually, because of the multiple changes again of the leadership roles in that Department, and the surgical job planning was probably the worst area in the Trust. 15:57
There were other areas where it was quite good and regularly done and meaningfully done. But I personally don't know that the electronic system we had was really much of a help. In some ways it was a hindrance.

235 Q. You mentioned that appraisal is a tool for individual development, not really for monitoring. But appraisal can be used effectively if there's enough intervention in terms of really looking at the data available and that being provided? 15:57

A. Yes. 15:57

236 Q. Was the barrier to that not having a specific Deputy Medical Director who could devote themselves to that? Was the barrier cultural? Your mechanics seemed to be working fine but meaningful discussion was not necessarily available for us to look at. 15:58

A. That's a very good question. The mechanics at the time I was there did work very well. Actually we knew when people were being appraised. We had almost 100% compliance. We did have a fairly advanced quality assurance check on appraisals, that the right questions 15:58
were being asked. What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves.

So for peer comparison within urology, for instance, that was not robust enough. Part of that would have been simply the culture within Northern Ireland medicine. There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful. 15:59 15:59

237 Q. It takes a lot of time to do it well?

A. It takes a lot of time to make it really work. I think the colleges could have a role in this, to be honest. For example, radiology, I was a radiologist. Getting hard data on a radiologist's performance is quite difficult but the colleges are best placed on what is reasonable to expect. I think they have sort of ducked their obligations there. They've stayed back from coming out. In something like surgery where they could say 'return to theatre, complication rate, mortality. There are indicators that could -- 15:59 15:59

238 Q. There's nothing to stop the Trust doing that either though?

A. There is nothing to stop, but it is much easier to introduce if you have the colleges saying, 'this is what you should do, folks'. 16:00

239 Q. One last question. NCAS, a really important tool. Why did you delegate the task of speaking to NCAS at the

beginning to Simon Gibson, because when I was Medical Director I would always have done that myself.

A. I think there was just too much going on at that time and I knew we had to inform them quickly. It wouldn't normally have been my practice. I would have spoken to them. In fact, I can't think of any other case where I would have done that. It was simply -- and I can't remember what it was, but there are other things going on that I just couldn't make that call on that day. 16:00

240 Q. In that context you would then normally seek some sort of assurance about the support being offered, would you, in the Directorate? NCAS always say 'support them through whatever you're doing'. People don't always know what that means. It can mean lots of things. Is that built into your processes now that you actually know what they're doing to support the doctor? 16:00 16:01

A. To be really honest, I don't know what the process is now within the Trust because I have been gone for quite a few years.

241 Q. I'm really asking for your view on that? 16:01

A. It is very important. Both the doctor who is the subject of the Inquiry but also the doctors who are the -- well, any staff who are involved in being interviewed or being involved --

242 Q. Correct? 16:01

A. -- and they people conducting the investigation where these things can be quite traumatising and very difficult for them.

243 Q. Would you recommend that that's always brought back to

something. Not the equivalent of the Oversight Group, I mean there has to be some group to discuss these things.

A. It would help if that was formally -- I mean we looked at this again, worked around SAIs with a similar sort of experience that it wasn't consistently reassessed, 'are we doing this? What is left that could still be done that we haven't done?' It happened very patchily. And I think the same applies for MHPS. 16:01

244 Q. You have to get the assurance back automatically, don't you? 16:02

That's all from me. I'll stop torturing you. Thank you.

CHAIR: Thank you, Dr. Swart. Mr. Hanbury, have you any questions? 16:02

245 Q. MR. HANBURY: Thank you. I've got not nearly as many questions, you will be relieved to hear, and some have been asked already. I have one thing on job planning. We heard evidence from Colin Weir that he didn't seem to have a lot of trouble doing the job planning for other surgeons, not necessarily urologists, and one of the sticking points appeared to be the large number of administration sessions that Mr. O'Brien wanted. Actually, having done a reasonable amount of job planning myself, the rest of his job plan was fine and standard, the number of clinics, sessions, etcetera. What do you think should have happened then? I think it went up the food chain once, but when Mr. Weir, his 16:02 16:02

description to capture what some of the roles should have been about, and also then I think the culture throughout the organisation was that the relationship between medical leaders and operational leaders wasn't a partnership, you know that - and I think it was borne out of a lack of understanding I think at times of what that partnership could actually bring, but also I think an anxiety about, you know, making appropriate demands on the relationship, because I do think - my sense is that the managers within the Southern Trust at a point in time I think felt that they were, you know, encroaching on even medical leaders to ask them for help, and then vice versa, I think often the medical leaders didn't automatically recognise it was their role to become involved. And, you know, the pattern at times seemed to be that when there was a clinical crisis of some description where they needed medical involvement then the doctors were asked for help, but usually outside of all of that it didn't seem to work as a partnership. 10:37 10:37 10:37 10:38

31 Q. Yes. And I think, if we just scroll down I think there's - yes, the integration point maybe echoes something of what you've just said. The role of Clinical Directors is less clear than that of Associate Medical Director, but there's clarification of the medical leadership roles with more structured engagement. It's this sense that the, at that point in time the state of the leadership arrangements, the management arrangements, could have benefitted from 10:38

interest is within the Surgery sector. You think by the end of your tenure the place was in a better state of health than when you arrived because you oversaw improvements. If we just go back to the beginning. In 2015, how would you assess the state of health of medical management within Surgery in particular, and what ultimately did you do to move it on to a better place?

A. The post holders had been in post for a considerable time. In Surgery in particular the Associate Medical Director and some of the Clinical Directors were approaching retirement, so that gave an opportunity to refresh and renew, I think, and just to look at how the system worked. There were particular challenges in Surgery because we were trying to deliver acute surgical services across two acute hospitals with a very small team, so that was problematic. As has recently, there have been developments in the public sphere recently where that service has been re-profiled within the last few months. We were still trying to manage an acute site on two sites. When they indicated they were retiring it was challenging to fill those posts, and it took quite a wee while before we had a static workload or workforce in those posts. I think there had been difficulties in the past with relationships within the Directorate between individuals and between some of the surgical team which didn't help things and took a while to settle down, it's probably fair to say. I like to think that the

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opportunities for people filling those posts were improved by the amount of training we did over three years that I was in office with doctors who were interested in management roles. This was something they had sought and we designed a bespoke training programme around clinical management for doctors, in association with the Leadership Centre and our own Human Resources Department to try and fill the gaps that they saw in their own training and to encourage medical management as a possible career path. One of the main stumbling blocks, I think, would have been the amount of time and resource given to clinicians wanting to take on those roles. There would have been limited programmed activity or PA allocations for them, and limited administrative support staff to help them in the roles. Part of this was because of funding issues, but, to be fair, a large part of it would also have been the clinicians themselves who really didn't want to give up significant parts of their clinical practice to take on these roles. They would prefer to do them on top of full-time posts. 10:09 10:10 10:10 10:10

53 Q. Yes. Just if I can come in on that, and we can continue the discussion along this. If I can frame it in this way: Mr. Haynes, in his evidence, painted a picture of a busy clinician. 10:11

A. Mm-hmm.

54 Q. He had a role in Belfast as well as a role in Craigavon?

A. Mm-hmm.

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

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

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

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

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

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

67.1. Having now worked through the documentation available to me and the results of RCA SAI reviews and the MHPS investigation findings, I have reflected extensively about what went wrong.

67.2. On occasions there was a tendency for the directorate and urology team to work around Mr O'Brien rather than appropriately deal with issues when they initially arose. This may have been out of deference to his seniority within the unit.

67.3. When I initially came to the Trust in July 2015, it became apparent to me that there was a lack of trust between Consultant medical staff and some of the senior medical and non-clinical leaders over a number of preceding years. This seemed to be an issue particularly within the surgical and anaesthetic teams. There was also a lack of knowledge among many of the medical and non-clinical leadership staff regarding possible options open to them for dealing with difficult issues among colleagues. Mr O'Brien was probably the most senior colleague in the entire Trust which was an added factor. This may have led to a reluctance for medical staff to escalate some significant issues

67.4. I spent considerable time in my first year as Medical Director rebuilding the senior clinical leadership team, starting at Associate Medical Director level based on a sense of real teamwork, openness and trust. I observed the interactions between my AMDs and I was convinced that this was beginning to yield dividends around Autumn 2016. By the time I left post we had an excellent, fully functioning, gender and ethnically diverse AMD team with the correct skillset to move forward.

67.5. The multiple changes of Chief Executive over the time period (six Chief Executives from March 2015 to March 2018) meant that it was difficult to move strategically important decisions forward. (I had been keen to strengthen the medical leadership team by appointing two deputies who could focus more on governance and professional issues but this proved impossible in my time).

first few months of arriving in the Trust. They were on my desk. Mr. O'Brien was not at that stage.

64 Q. You say, if we could just bring it up, WIT-17894, and paragraph 67.3:

10:23

"When I initially came to the Trust in July '15 it became apparent to me there was a lack of trust between Consultant medical staff and some of the senior medical and non-clinical leaders over a number of preceding years. This seemed to be an issue, particularly within the Surgical and Anaesthetic teams. There was also a lack of knowledge among many of the medical non-clinical leadership staff regarding possible options open to them for dealing with difficult issues among colleagues. Mr. O'Brien was probably the most senior colleague in the entire Trust which was an added factor. This may have led to a reluctance for medical staff to escalate some significant issues."

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I am anxious to explore maybe the general point you make first about the Trust issue. Can you better explain that or broaden it out for us?

10:24

A. Okay. I remember coming to the Trust and having my first Associate Medical Director team meeting and being surprised at just the general atmosphere within the meeting, which was not open and appeared to be quite defensive. So, that was a significant issue which had to be addressed fairly early on. Some of that was because of interpersonal issues that had obviously been

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going on for a while between some of the team members, and between them and previous issues before my time. I made it very clear at the start that we were going to change that culture and behaviour, and we set out deliberately to do so at a very early stage because that was unacceptable to me. I think, by and large, that was welcomed by most of the people that were there. We went on an away weekend, if you like, specifically to tackle this issue of culture, and we brought in expertise from the Beeches Health and Social Care Leadership Centre, and we took a stock-take of where we were with that. Part of that was to identify training needs. I think possibly, to be honest, that was where some of the members maybe felt that it was time to move on to do other roles and it was time to refresh some of the team members, which was part of that process as well. I think, to be fair, that turned around fairly quickly. I'm not sure what the original source of all that was but it was a very definite -- maybe it was a mistrust of me coming in from an outside Trust, it may have been that, but, certainly, my modus operandi was that we were a team, that even though we had certain areas of Directorates to cover, there was to be cross-cooperation between the AMDs and mutual support, and that was the way they were going forward. It was a factor right at the start but it was fairly rapidly turned around.

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65 Q. Just a discrete point lying within that paragraph:

back to what I said earlier on about appraisal, it is harder to do a full-on challenge when you need people giving you advice and helping with your own patients. I think that is probably one of the biggest things that is hard to divorce, you know, from being a manager having to at the same time making sure your patients get the best possible deal in the end.

Slightly more specifically, Mr O'Brien was reluctant to change in most aspects. He believed that what he did was the best for his patients and that he was doing the best for his patients and, therefore, probably we were interfering in that.

MR. WOLFE KC: Okay. I think we can leave it there for now.

CHAIR: Twelve o'clock.

MR. WOLFE KC: Yes.

THE INQUIRY BRIEFLY ADJOURNED

CHAIR: Let's continue.

MR. WOLFE KC: Just before the break I was asking you on a general level about the difficulties that you encountered in managing colleagues who were presenting difficulties. The first thing you said was that you work closely with these people who are required to continue delivering clinical services for the benefit of the organisation. Did that reflect a sense that it is an uncomfortable task professionally and personally,

"There was also a lack of knowledge among many of the many medical non-clinical leadership staff regarding possible options open to them for dealing with difficult issues among colleagues."

A. Yes.

66 Q. What are you getting at there?

A. I think particularly options such as the MHPS process. People had a very superficial understanding of how it operated and what help could be attained from it. There wasn't a great awareness of the goal of NCAS and the National Clinical Service, for instance, and the potential it had to assist and help with difficult cases. My way of working was, where problems were identified, to deal with them at an early stage, to intervene with a process that was overseen by the Trust Oversight Committee, with a view to preventing them escalating into more serious issues. When I arrived in the Trust, there were a number of issues that had clearly been going on for some years. Some of them had been dealt with and there were a few outstanding ones. I made it clear to my AMD team that was going to stop and that the way forward was to deal with issues by the appropriate process in a formal manner. The reason for doing that is often you can prevent a relatively minor issues from escalating to a more major one, before behaviour becomes entrenched. I have had experience of that in a number of previous areas where that has worked well, and I have seen the effects where not doing that has led to very significant problems that

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are almost impossible to fix if left un-dealt with. That was part of the reasoning behind developing then the training package for clinicians for medical management.

67 Q. Yes. Obviously, just to pick up on your point about knowledge of MHPS and understanding of its import and how to use it, you are coming obviously with a background in a bigger Trust, probably more throughput of MHPS cases with a larger demographic? 10:28

A. Yes. 10:29

68 Q. Could I suggest to you that really should only be part of the explanation for the lack of knowledge that Mr. Mackle and, for that matter, Mrs. Trouton, revealed in their evidence over the past couple of days. They didn't seem to know too much about MHPS at all. In Mr. Mackle's case that was notwithstanding that he had been asked to be a Case Manager once, and Mrs. Trouton, for her part, had never heard of it. 10:29

A. Mm-hmm.

69 Q. Is that surprising to you when I put it in those terms, given their roles in senior operational management and senior medical management? 10:29

A. It clearly couldn't be allowed to continue. You can't have an Associate Medical Director who is ultimately unfamiliar with the MHPS process, which again is one of the reasons why we developed a bespoke training programme for them because it was apparent that there was a deficiency of knowledge amongst senior clinical staff in that area, and that did surprise me, but it 10:30

to you directly or was this information you might have picked up?

A. This was information I picked up on the way round. I never had a formal approach. Probably the person who came closest to it was Mr. Haynes in terms of identifying, you know, and he put those emails in terms of what he had identified. I didn't have a formal approach from anyone else to say, I am discerned about Mr. O'Brien.

116 Q. He might have been difficult to manage but you were being paid to manage him, you were the Medical Director. 11:25

A. Yes.

117 Q. That was your role?

A. Yes. 11:25

118 Q. You were a couple of roles above his grade. There were people below you paid to manage him, but ultimately you were in charge of the medics. Was there any other factor, anything else that prevented you from dealing with him directly? Mr. Haynes has referred to being frightened of the fear of litigation, family members and the law. Did any of that play any part in what you heard or how you felt? 11:25

A. I heard that through the system. I think what made the job of managing more difficult, I think, is the facts you referred to there, among other things, was a concern throughout the system about Mr. O'Brien's connections. You know, one of the first things I heard about him was he had legal connections. Then the other 11:26

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.

to pressures rather than be able to always to look up and out and gain oversight and plan. We are in the process of significant changes to the Senior Management Team and this will allow opportunity through induction and training to develop systems' leaders cognisant of the learning form this and other Public Inquiries. To do this we will are in the process of involving the Leadership Centre and the King's Fund. Some of this work has started.

8) Training in Group and Organisational Dynamics, that is the psychological understanding of how groups and organisations function, is required, will support the approaches mentioned in the previous paragraph, and is being explored.

9) In addition to this I am implementing operational structural changes to the Trust by changing the roles and responsibilities of the directorates and developing 2 new directorates by splitting the functions of the current acute directorate into two parts in broad terms corresponding to i. Unscheduled Services and ii. Surgical, Cancer and Laboratory Services. This should allow a greater patient safety and governance focus throughout the organisation, particularly in Urology services. These changes will also coincide with the retirement of Mrs Melanie McClements in August 2022.

10) Whilst In the past there has been a number of changes and a loss of continuity and memory, the aim of the current changes is to develop stability and governance while improving patient experience and value for money. ATTACHMENT: SMT RESTRUCTURING document located at *S21 No 29 of 2022, 260. Structure Paper final arrangements June 2022*

11) To support this and through the work already started with the Medical Governance reforms in the Trust we will develop governance accountability structures through a triumvirate structure of Divisional Nurse, Divisional Doctor and Assistant Director reporting to SMT and Trust Board through the respective directors in order to strengthen

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

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

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

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

15) Often these team cultures are developed and led by the most senior clinicians particularly if they are charismatic.

16) In addition to this, due in part to the changes in Medical Director in recent times, the communication between the appraisal system in the medical director's office and the medical managers required to be more robust. Mr O'Brien chose his own appraiser and brought only the information he wanted to. This process has now been developed as explained in my answer to Question 36.

17) This resulted in Mr O'Brien being appraised without all of the information in relation to the concerns raised in 2015 and the ensuing Maintaining High Professional Standards Investigation not being known to the Appraiser as it was not declared during the Appraisals by Mr O'Brien. This resulted then in an inadvertent false assurance on quality and safety performance being given by the appraiser, and thus loss of the opportunity to learn for improvement.

18) In addition to this, the quality of material brought to appraisal can be variable and this requires to be standardised through the development of professional governance dashboards that allow for information to be readily available to appraisees, appraisers and line managers in real time.

19) Another potential weakness in this system was the ability of the appraisee to choose their own appraiser from within any grade of permanent medical staff including those employed as a less senior grade. This ran the risk of appraiser and appraisee appraising each other and thus limiting the ability for learning from concerns.

20) In addition to this, feedback from patients and peers was invariably positive which again limits the ability to learn from concerns. The Trust is considering how this might be undertaken more objectively.

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orthopaedics within the Trust. Expansion of urology. It was a wide-ranging and extensive role which was done as part of my -- on top of my full clinical job.

MR. WOLFE KC: I'm conscious, as everybody will appreciate, that we have you along today to reflect upon your experiences of managing a particular doctor who was in difficulty or was causing difficulties, depending on your perspective. Is it fair to suggest that what I've just said is one small element of a much bigger role? 10:51

A. Yes. Urology was one of the smaller sections of my remit. There's all of general surgery in Craigavon, in Daisy Hill. There was development of the trauma and orthopaedic service; there was ENT, and to a lesser extent ophthalmology services to be provided from 10:52 Belfast -- with an orthodontist.

MR. WOLFE KC: I think you reflect at WIT-11750, at paragraph 46, I suppose the impact of the job on you and the toll it had. It was a stressful role?

A. Yes. 10:52

MR. WOLFE KC: You say on a personal level you don't believe you had sufficient support and time available to fulfil all the duties of the role.

A. The role was extensive. The job description is extremely extensive. The role was extensive but this 10:53 was on top of being a full-time clinician. Part of that was - and I said at the time I was asked to take it up, would I apply for it - if I had given up my subspecialists, I would have had more time but if

I ceased to be AMD, I couldn't take those back up again. That was my priority; my priority was the surgical work which I did with my patients for oesophageal surgery and for colorectal.

MR. WOLFE KC: So, the balance was very much tilted towards your clinical practice and maintaining that, because that was your raison d'être? 10:53

A. The vast majority of my PA allowance was for clinical work.

MR. WOLFE KC: We'll come to that shortly. Thank you for those preliminary reflections. 10:54

If we go back to your job description at WIT-11836. Just scrolling through it, you can see at the bottom of that page it talks about key area results, of which there were eight. Strategy and development, service delivery, professional leadership. If we could just pause there. It says within that - this is the third bullet point - that it was part of your role to ensure the highest standards of clinical, effectiveness and medical practice in the directorate, including the implementation of local and national recommendations and NICE guidelines, etcetera. Did you regard that as a key element of your role? 10:54 10:54

A. It was a distinct part, I'm not denying that, but it was part of all of the role. At that time there was a significant push on the Trust as regards performance. A significant amount of our time at managerial meetings were spent on performance, to meet targets, etcetera. 10:55

but in being able to assure SMT And Trust Board that the systems and processes that are in place to support those are robust.

37 Q. We'll go on to discuss the information you've provided in your Section 21 as to how you, as Medical Director, ensured those systems were robust, or at least relied on them in order to provide assurance to the Board? 10:24

A. Yes.

38 Q. When you took over from Dr. Khan, was there a handover at that point? Did he provide you with a handover? Did you have either a formal or informal handover as he departed the role? I think you overlapped. He left in January 2019 and you took up post in December 2018? 10:24

A. In December 2018 I had leave to take, and I also had the remaining weeks that weren't Christmas to take as an induction. So basically given I had never worked in the organisation that was about me familiarising myself with some of the key people there. The handover took the form of 2 pages, which I think are submitted in Dr. Khan's submission and mine, basically with a long list of areas that he had been involved in. Then I think we met for about an hour and a half and he took me down through some of the aspects of that. There was not, I have to say, a huge concentration at that point in time in relation to Urology. I think he explained they had been through a Maintaining High Professional Standards process, but a vast majority of the rest of the discussion was around different aspects of the Trust he had been concerned about and that, 10:25 10:25 10:25

essentially, was the handover.

39 Q. Was the Maintaining High Professional Standards, was that only one of those, or had other doctors been put through that process and reflected in the handover?

A. There were others ongoing at that point in time. 10:26
I had, again as part of my induction, I joined a matter with the GMC ELA, I think, on 4th December, basically to get a handover from that aspect of it to learn about those doctors. Again, Urology was mentioned there but very much in the context of Maintaining High 10:26
Professional Standards has been done and finished. There was an awareness that a grievance had been placed at that point of time, but other that there was little discussion about it.

40 Q. Was that the meeting you had about Dr. Khan and Joanne 10:26
Donnelly?

A. Yes.

41 Q. That was referred to, Panel, for your note WIT-44957, paragraph 1.4. I will just read that out because you have referred to that as being part of your handover 10:26
and I want to look at that a little bit more.

"As part of the hand-over between the then Interim Medical Director Dr. Khan and the GMC ELA Joanne Donnelly, I learned that an MHPS investigation had been 10:27
carried out in relation to a Urology Consultant, the result of which was an action plan in relation to administration activity. There were not thought to be any concerns about his clinical practice and did not

a Head of Service could be brought in. I think that's -- you know, if it was me, I think that's a great model. I think that's what I would want to emulate that, but I would, maybe periodically, have maybe a meeting of a wider team and a better channel to channel the information. But that two-way flow I think was a good way of doing it.

246 Q. But it wasn't wider across the Trust?

A. I couldn't see that being replicated anywhere else. I know in my own role managing trainees we had a regular monthly meeting with -- we had all the trainees come and meet us. It was all about, again, a two-way flow of information and traffic. So I quite like that model. I think I would sort of say definitely go with that. 13:11

247 Q. A similar vein; there have been quite a few references to assurances around the clinical practice of Aidan O'Brien, but this could be about the assurance of clinical practice of anybody. What direction did you have from the Medical Director, for example, as to how, as a Clinical Director, you should be developing ways of assuring the quality of your service so that it was safe patient experience? Were you given strategic direction on that? 13:12

A. No. The job plan, which is just too much -- there's far too much in the job plan for Clinical Director. That is not a template, really, for working as a Clinical Director. I mean the Trust at that time, and I'm sure continues to send consultants with 13:12

potential management role and interest on, you know, medical management courses, but I think within the Trust there needs to be some sort of induction programme into your role. We get inducted into everything else, so why can't we be inducted at local Trust level as to what's needed of you, who do you report to directly, what's the chain of command. I guess we're supposed to know these things, yes, but just somebody to say, right, here, this and this and this, and then here's somebody else to tell you what the current live issues are and what you need to do. 13:13

248 Q. The public will want to know now how are we assured that urology services, because we are here now, but any services are safe? As a Clinical Director did you regard it as in your job description to try and develop a way of doing that? 13:13

A. Yes, but there wasn't enough. I guess because there were so many other issues going on there wasn't enough time to dedicate yourself to that role. It is probably a role, if you are going to be strategically thinking, doing good governance, then you need a lot more time to it. You need a day a week perhaps to do it. 13:14

249 Q. Looking back on it now, you can, I'm sure, see these things even more clearly in the context of this, but one thing that stands out as well is a reluctance to sit down with the individual concerned, and meet and talk and understand. Do you think, with hindsight, there should have been someone undertaking that role, and who should that have been? 13:14

results set up draws results under the names of 3 locum consultants, Mr O'Brien and myself). However, this is not without challenge. This workload is all the patient-related administrative workload of a colleague, the service is already unable to meet demand and so, to free a clinician from clinical duties to conduct this workload, would result in a widening of the gap between capacity and demand. Additional activity (as Waiting List Initiative / WLI) is offered to the team for this activity but, due to a variety of factors, this offer is often not taken up and the activity often conducted during individuals' own time. When vacancies become longer term, and are associated with outpatient and inpatient waiting lists, they create additional challenge as the remaining clinicians cannot absorb the operative and outpatient workload without negative impact on the patients already under their care.

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

19.1 This matter has already been covered, in part, across questions 16, 17 and 18.

19.2 From a personal perspective, it has had a direct impact on the time committed to my role as AMD. Until November 2021, I did not include the full 3 PA requirement in my job plan as I endeavoured to deliver clinical care and this meant that I was not able to deliver fully my role / responsibilities as AMD. Additionally, at various points during my tenure as CD / AMD, all of the clinical management posts (CD / AMD) have been unfilled adding to the workload of the medical managers in post and, upon commencement and due to the events which led to the departure of the previous AMD (Dr McAllister), I did not receive a handover or induction into this role. I also regularly conduct core aspects of my clinical activity (patient related admin) in my own time (typically from approx. 5:15am in the mornings, both weekdays and weekends). I regularly continue to address patient related admin and results throughout periods of annual leave.

19.3 The mismatch between demand and capacity, and the strains of delivering care within current capacity (with consequent bed pressures, increasing

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51.6 Within the Acute Directorate, specific risks identified may be recognised on the Risk Register. I have commented elsewhere in this statement (e.g., at Q46) that it is my view that the concerns related to the capacity:demand mismatch are not reflected adequately on the Risk Register. *Please see:*

53. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1. Nov 2016

54. 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure

55. Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

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

52.1 As consultant, I have felt supported by the medical line management hierarchy. For example, when I was approached with regards in-reach into Belfast Trust for nephron sparing surgery, the Southern Trust medical and professional management teams were fully supportive of this, despite the local impact of a reduction in the clinical time I spent in Southern Trust, recognizing the system wide benefits.

52.2 When I started as Clinical Director, and subsequently Associate Medical Director, no induction process was afforded to me and, in particular, when I commenced as AMD no handover period or process was in place. In particular, I did not receive any briefing of any prior or ongoing concerns with regards to medical staff. It is notable that no AMD was in post for approximately 12 months between Dr McAllister's departure and me taking up the role.

52.3 During my time as a medical manager, I have raised a concern that no additional administrative support (e.g., PA) is available to clinical managers, although it is provided to professional management colleagues. Certainly, for

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47. 20210719 Approved Action Plan to HSCB A1 and 119. 20190331_RE Urology backlogs Confidential.

62.7 When I commenced as AMD, I did not receive any handover from the outgoing AMD and so was not aware of any prior issues or investigations relating to Mr O'Brien. Relatively soon after starting as AMD, Mr O'Brien had a period of Personal Information redacted by the USI leave. I recall that it was during this period of Personal Information redacted by the USI leave that the concerns regarding non-triage of referrals escalated with a significant number located in Mr O'Brien's office. It is my memory that this was identified as a potential issue in the course of the Patient 10 SAI investigation (following an IR1 submitted by me relating to a patient who was referred with regards a renal lesion - the primary issue of this IR1 was a misreported MRI scan but it was noted during the SAI that the referral had not been triaged). At this time and following on from this, I recall a number of meetings with urology consultants (primarily operationally identifying capacity for triage of all the untriaged referrals and the subsequent patient assessments required). I also had a number of conversations with the HoS (Martina Corrigan), AD (Ronan Carroll), Director of Acute Services (Esther Gishkori), and the Medical Director (Richard Wright) regarding this issue and the additional concerns relating to absence of dictations, medical records being in Mr O'Brien's house, and preferential management of private patients were also investigated. I do not have notes from these informal meetings / discussions.

62.8 As a result of these concerns an MHPS investigation was opened and I was interviewed as part of that investigation. I do not recall when the discussion was held but, as part of the conversations with the Medical Director, it was agreed that, given my proximity to Mr O'Brien as a working colleague and given that I was the individual who had raised IR1s and concerns regarding Mr O'Brien, it would not be appropriate for me to be party to the MHPS process for Mr O'Brien. As a result, I was not part of the MHPS discussions nor was I party to the subsequent report, recommendations and monitoring.

62.9 Soon after commencing as Medical Director, in early 2019 Maria O'Kane spoke to me regarding Mr O'Brien and the MHPS investigation and concerns being escalated to the GMC. However, I do not know/recall whether this

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I think that administrative support for Clinical Managers, which wasn't present, I think is required.

66 Q. You mention I think several times in your witness statement that one of the things that I suppose to some extent hamstrung you in the role was the absence of a handover. Just unpack that a little. Does your complaint in that respect suggest that you got your Letter of Appointment and the next day you were AMD and were just expected to know the role? 15:06

A. Yes. As I said, I've mentioned induction or handover, I think I have mentioned both, so, yes, so essentially you became AMD and you were in the role. 15:06

67 Q. No training, no orientation, no induction, no informal chat about current and developing issues?

A. You would have had an informal chat, or I would have had an informal chat with the Medical Director when I was considering applying for the post of AMD then, but I wouldn't have had an induction and handover from the previous AMD. Obviously it was difficult at that time because there hadn't been a previous AMD for 12 months either. 15:07 15:07

68 Q. Knowing what you were to discover in relation to the series of Mr. O'Brien issues as they became reported, was there anything that was terribly new to you that might have -- or put it another way. Was there anything terribly surprising to you that could have been alleviated or assisted with the handover? 15:07

A. I think a handover or an induction in terms of how you fit within the -- as you have described the Governance

manage for a long time and had got into difficulties since 2015/2016, and, again, the narrative at that time was if the administration processes could be sorted out, that would get him back on track again. Right? In hindsight, knowing now what I know, these difficulties were going back to at least 2009 and that, actually, you know, these were symptoms of something else, not what they looked to be on the face of it. I think I would have approached it differently. I do think if I had known then what I know now, my approach to this would definitely have been different. Right? But I also think, in fairness, the one person in all of the middle of this who knew his entire history was Mr. O'Brien. Again we were relying, I think wrongly at this point in time, on his probity and honesty in relation to letting us know if he wasn't doing the things we asked him to do, and at no time did he present that information. 14:18 14:19 14:19

262 Q. The next sequential email for the purposes of this engagement is TRU-252529. It is an email from you sent on 8th October 2019. You'll see your name at the top of it and the date 8th October 2019 from you to Mark Haynes, Melanie McClements, Dr. Khan and Siobhán Hynds, subject AOB-oversight meeting. Attachment, urgent, AOB concerns, urgent, oversight meeting request, action plan. You have written this. I'll read it out for the transcript? 14:19 14:20

Discussion draft notes:

like.

159 Q. It's very honest of you to say that it crossed your mind but what I'm asking you is why would it cross your mind, never having had any dealings with him before, that this might be a bit of a trick or on his part to 15:05
suggest the 1st July, thinking that you may disagree with it?

A. Mr. O'Brien was a consultant psychiatrist when I was a junior -- sorry, a consultant urologist when I was a junior doctor. I suppose I knew of Mr. O'Brien, 15:05
I knew he was a very formal man and I knew he was a very senior colleague. I suppose I did wonder how he would -- these investigations are supposed to be undertaken by somebody of a reasonable seniority in terms of Associate Medical Director, or a Clinical 15:05
Director if you are investigating a consultant. I did wonder whether he might feel that I was a bit of a whippersnapper. I did wonder whether he might feel that because of the fact that he was really quite senior to me in terms of experience and years. So, 15:06
I did wonder about that. As I say, knowing that he was quite a formal, proper gentleman, I did wonder whether he -- it did cross my mind. I mean it really was as simple as that. It crossed my mind, I dismissed it and said yes, Saturday will do. 15:06

160 Q. I am sorry to press you on this, Dr. Chada. You had no basis at all upon which to be suspicious of Mr. O'Brien's motivations in suggesting this date?

A. No, no, not at that time. As I have said, it crossed

bit concerned. It was just, look, are we doing the right thing here, are we not? What's going on, whatever?

262 Q. We will come on to the email. It was 2019.

A. '19, right, okay. 11:58

263 Q. We will come on to that in a second. From your perspective, your lens was entirely systems functioning?

A. Yes.

264 Q. And things continuing to operate smoothly? 11:58

A. Yes.

265 Q. You have said in your statement at paragraph 26.3 that Mr. O'Brien instructed his secretary not to use DARO. Was that something that was reported to you or did Noleen Elliott tell you that directly? 11:58

A. Noleen Elliott told Colette McCaul, who was her line manager at the time, and Colette McCaul then told me.

266 Q. Was there an expectation that Noleen Elliott - we discussed this slightly earlier - would follow the guidance that DARO was the system in place? Or was 11:59 there an expectation that she would use systems to better reflect the clinic practice of her consultant?

A. Well, it's a very tricky one but I believe the secretary should be listening to us because we are the admin people and you should be following your 11:59 instruction from us. However, I understand it's very difficult because she worked very closely with the consultant; you see them as 100 times more important than we will ever be. But you have to follow process

the necessity to put the safety and quality standards at the top.

257 Q. That leads me to, you'll be glad to know, the final question that I want to put to you.

16:18

As someone with the experience that you had of MHPS, and you described at the outset of your evidence to us that you were a founding member of the Faculty of Medical Leadership and Management, and that has been your career path, largely, if you had to sum up one thing, what do you think was the cause of things going awry here? Because it is quite clear to us that things did go awry.

16:18

A. Inappropriate deference based on status rather than ability.

16:18

CHAIR: Thank you.

Thank you very much, Dr. Wright. We do appreciate you had to come back on a second occasion. Just for the benefit of everyone here, in our down time next week we will be looking at our timetabling to try to avoid having to call people back on a second occasion, if at all possible. I have to say, we might not manage it, but we will make every effort so that people will only come and speak to us once.

16:19

16:19

A. Thank you very much.

CHAIR: Tomorrow morning, Mr. Wolfe, we have Mrs. Toal.

MR. WOLFE KC: She's here now. We could get started.

CHAIR: I don't think that would be fair on any of us,

directorates. The detail of this review has been set out in response to Question 39 above.

(2) Medical leadership Review: I was aware of the importance of strong medical leadership in improving patient care and safety. Therefore within the Medical Directorate we started an exercise to gather feedback from current Trust senior leaders including AMDs, CDs, and service Directors.

a. The Feedback report indicated a lack of focus in developing medical leadership in the Trust.
b. Therefore, a Medical Leadership Development Paper was developed and shared at SMT meetings. This paper proposed a revised medical leadership structure. Apart from other proposed changes it suggested 2 dedicated Deputy Medical Directors, one with responsibilities of patient safety and quality and the other with responsibilities for medical workforce development and staff performance at corporate level within the Medical Director's office. This paper also proposed dedicated time in M&M chairs' job plans.
c. It was presented to SMT meeting in September 2018. I handed over to the new Medical Director (Dr Maria O'Kane) after her appointment to progress. **Medical leadership paper attached** *and can be located at S21 No 28 of 2022 Attachments, 22. Medical Leadership Review 2018 Draft-V11- September 10*

(3) Health Care Acquired Infection / Infection prevention control (IPC): Healthcare Acquired Infection / Infection prevention control (HCAI/IPC) was another priority as the Trust was facing challenges in this regard. I led a small working group to engage with staff and draft an IPC strategy. The IPC Strategy was presented at SMT and Trust Board before I completed my tenure in December 2018.

Evidences:

- **IPC Strategy attached** and *can be located at S21 No 28 of 2022 Attachments, 21. IPC Strategy 2018-21 TB Paper 27.9.18 final*
- **Medical directorate structure** *can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

Concerns regarding the urology unit

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.





Medical Leadership Review

Revised March 2020

Senior Management Team Meeting - Date 10th March 2020





Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

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Section 1 – Medical Leadership Structure Review Framework

1. Background and Context

1. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation[1].

2. Leaders need to ensure that all staff can adopt leadership roles in their work and take individual and collective responsibility for delivering safe, effective, high-quality and compassionate care for patients and service users. Achieving this requires careful planning, persistent commitment and a constant focus on nurturing leadership and culture.

3. With this in mind good medical leadership has been identified as vital in delivering high-quality healthcare[2]. There is an increasing body of published literature that links the performance of units to levels of medical leadership[3].

4. To achieve competence in strong medical leadership doctors are required to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which modern health and social care is delivered[4].

5. The divisional medical leadership structure within the SHSCT last underwent a review in 2011 where medical leaders functions, responsibilities and accountabilities were considered. Corporate leadership roles were introduced to support medical revalidation processes, GMC responsible officer requirements and to support the development of SAS grade doctors.

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[1] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*
[2] *Warren OJ, Carnall R Medical leadership: why it's important, what is required, and how we develop it Postgraduate Medical Journal 2011;87:27-32.*
[3] *Clark J. Enhancing medical engagement in leadership. InView 2006;10:14e15.*
[4] *Darzi A. A time for revolutions – the role of clinicians in health care reform. N Engl J Med. 2009;361(6):e8.*

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6. Over time there has been an erosion of the number and impact of these leadership roles which in turn has affected morale, recruitment and retention of staff, particularly doctors. (See section 14, p 22)

7. Given the length of time since the 2011 review and the significant changes in the health and social care landscape it is now time to -re-visit, the Trust medical leadership form and function, based on an assessment of how fit for purpose it remains in a highly dynamic environment.

8. Any structure that emerges must drive a culture of effective, continually improving high quality, safe, patient / service user focussed services underpinned by quality improvement, education and research.

9. It must be open and transparent in its decision making. It must encourage all clinicians to contribute to Trust's strategic priorities and take responsibility for contributing their delivery.

2. Strategic Drivers

10. The Southern Trust must nurture a culture that ensures the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are fostered is fundamental[5].

11. The task of leaders is to ensure direction, alignment of purpose and commitment within teams and organisations. Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work.

[5] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*

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12. Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[6].

2.1 United Kingdom Regional Workforce Strategy Policy Direction

13. All NHS UK regional Departments of Heath have endorsed leadership models that require clinicians to become more actively involved in the planning, delivery and transformation of health and social care services[7,8,9,10.]

14. Current NHS Workforce Strategies are based on the concept of a shared or collective leadership model where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

15. Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services

"*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

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[6] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

[7] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*

[8] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*

[9] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*

[10] *National Leadership and Innovation Agency for Healthcare Wales*

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Department of Health England, Next Stage Review: High Quality Care for All

"Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership

"Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

National Leadership and Innovation Agency for Healthcare Wales

"Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. The Collective Leadership Model

1. The 2014 King's Fund paper titled 'Developing Collective Leadership'[11] stated the need to move on from a concept of command and control leadership to a shared and distributed throughout organisations. The report also argues that leaders must engage their colleagues and other stakeholders in bringing about improvements in patient care and transforming the way in which care is provided.

[11] West, M. A., Eckert, R., Steward, K., & Pasmore, W. A. (2014). Developing collective leadership for health care. London: King's Fund.

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2. A successful collective leadership model emerges from a conscious and intelligent effort to plan for an integrated, collective network of leaders distributed throughout the organisation and embodying shared values and practices[12].

3.1 Collective Leadership and Organisational Culture

3. The culture of healthcare, which so critically affects all other aspects of the service which patients receive, must develop and evolve to meet the needs of current and future service provision.[13]

4. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the merging culture of an organisation. [14]

5. An NHS Innovation review found that by enhancing the engagement of doctors in leadership there is potential for positive impact on both clinical and organisational performance. [15]

6. Due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. However, by engaging doctors within the collective leadership model, significant differences may be achieved which enhance performance.[16]

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[12] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[13] Kennedy I. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol. 2001
[14] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[15] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p16
[16] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p33

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4. Investing In Medical Leadership

7. Clinicians across Health and Social Care must be supported to lead and drive a culture that is Compassionate, Collective, Open and Excellent and which focuses on the quality and safety of services for patients and service users and the experiences of staff.

8. This can be realised through aligning the Culture and Values of the Trust with talent management and appraisal, along with supports to help make the necessary transformation into these roles.[17].

9. Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

10. The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[18]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[19]
- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[20]

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[17] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[18] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[19] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*
[20] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*

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- A study in the Harvard Business Review (2007) provides a strong link between leadership skills and organisational performance[21]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[22]

5. Review of Best Practice Literature

5.1 NHS Medical Leadership Competency Framework (MLCF)

11. The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

12. The MLCF describes leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice, Tomorrow's Doctors and also Management for Doctors.

13. While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professionals and therefore have an intrinsic leadership role within healthcare services.

14. Doctors also have a responsibility to contribute to the effective leadership and the running of the organisation in which they work and to its future direction. The development of leadership competence is an integral part of a doctor's training and

[21] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[22] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

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learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

15. The Medical Leadership Competency Framework (MLCF) is built on the concept of collective leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

5.2 Clinical Leadership Competency Framework (CLCF)

16. The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

17. The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

18. Doctors have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

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5.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

19. The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring:
    - The team has articulated a clear and inspiring vision of the team's work
    - There is clarity about the team's membership
    - Team members agree five or six clear, challenging, measureable team objectives
    - There is strong commitment to collaborative cross-team and cross-boundary working

20. The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

21. Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

6. Current Trust Medical Leadership Structure

6.1 Medical Leadership Structure (since 2011)

22. The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

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23. The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the discontinuation of three AMD positions, the rationale for this is unclear:

- **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
- **AMD Infection Prevention and Control – *Post not retained (2015)***
- **AMD Standard and Guidelines – *Post not retained (2015)***

24. The current Southern Trust Medical Leadership Structure is outlined below

Medical Leadership Structure Today (May 2019)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *3 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*
AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair

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CAH Medicine Chair*
Trustwide Surgery Chair*
Trustwide CYPS Chair
Trustwide IMWH Chair
Trustwide MHLD Chair

* *Medicine and Surgical Specialities are supported*

7. The Case for Change

25. Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

7.1 Performance of Frontline Teams

26. There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

7.2 Providing a Link from Bed to Board

27. Medical leaders understand the complexity of modern health care services and how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[23].

[23] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

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7.3 Supporting and Influencing Service Planning

28. Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.
29. Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes. Doctors are uniquely positioned to understand the potential impact of policy or funding changes[24].

[24] Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.

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8. Consultation with Trust Medical Leadership

30. As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model (2018/19). A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix 4. A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate PA allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

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31. The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

32. Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

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9. Consultation with Trust Directors

33. Trust Directors were asked to give their views and opinions on the current medical leadership structure (2018). A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role. A summary of key findings that relate to the current medical leadership model is found in the table below (appendix 4 contains full reponses).

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

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Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

34. The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

10. Comparison with Analogous Organisations

10.1 Northern Ireland Regional Trusts

35. The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust

• Medical Director (Director for Governance, Patient Safety)
• 2 Deputy Medical Directors
• Divisional Director Structure*
• Clinical Director Structure
  • Governance and Safety Roles
	• Medical Director (Director for Governance, Patient Safety)
	• 3 Deputy Medical Directors
	• Clinical Director Structure*
	• Associate Clinical Director Structure
	  • Governance and Safety Roles

Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director (Director for Governance, Patient Safety and QI) • Divisional Medical Director Structure	• Medical Director (Director for Governance, Patient Safety and QI • 3 x Deputy Medical Directors (5 PA

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• Clinical Director Structure* • Governance and Safety Roles	each post) • 12 Divisional Medical Directors (3PA per post) • 38 Clinical Director Structure* - including CDs for litigation, coronal affairs, appraisal and revlaidation (2PA per post) • Patient Safety Lead Clinicians**(1PA per post) • Governance Lead Clinicians (1PA per post)

*Clinical Directors are equivalent of SHSCT AMD roles

** Lead clinicians are formal roles within the medical leadership structure

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Section 2 – Proposed Medical Leadership Structure

11. Medical Leadership Development and Competence

36. A supplementary paper titled Medical Management and Leadership Development will follow.

12. Medical Leadership Appointments

37. It is proposed that if approved, all Medical Leadership management posts will be vacated and reappointed collectively.

38. This paper proposes that all senior medical leadership positions commencing from August 2019 are fixed-term appointments (details found in subdivision 14 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

13. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

13.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director position, responsible for providing assurance to Trust Board those effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services,

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	support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical and social care governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	WTE
Areas of Responsibility	Medical Professional Governance, Clinical and Social Care Governance, Medical Workforce Development, Patient Safety, Quality Improvement and Audit, Infection Prevention and Control
Appointment Term	Permanent Post

13.2 Deputy Medical Directors (3 Posts Total)

Role Description	**DMD – Professional and Workforce Development (New Post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	6 PA
Areas of	• Medical Appraisal & Revalidation

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Responsibility	• Job Planning • Medical Professional Governance • Oversight of Locum Doctors • Support and Oversight of International Recruitment • Medical Engagement and Recruitment • Coroner Services Oversight • Litigation Services Oversight • Oversight of Locum Management • Deputise Responsible Officer function for Medical Director
Appointment Term	Permanent

Role Description	**DMD Governance, Safety and Quality Improvement (New Post)** The Deputy Medical Director (Governance and Quality Improvement) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Clinical Leadership for Quality Improvement • Clinical Audit (National and Local inc. NCEPOD Ambassador) • Research and Development • Standards and Guideline Oversight • Infection Prevention and Control Oversight
PA Allocation	6 PA
Appointment Term	Permanent

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Role Description	**DMD Medical Education and Training (Existing Post Reconfigured)** The Deputy Medical Director (Medical Education and Training) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Undergraduate Education Leadership and Development • Postgraduate Education Leadership and Development • Physician Associate and Medical Associated Professions Governance • SAS Grade Leadership and Development
PA Allocation	4 PA (Currently funded at 2.5 PA)
Appointment Term	Permanent

13.3 Chairs of Division (9 Posts Total)

Role Description	**Chairs of Division (Operational Services)**
Number of Posts	9 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine • OPCC • Emergency & Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services
PA Allocation	PA between 2 and 4
Appointment Term	3 Years Initially

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Role Description	**Associate Medical Director – General Practice** Associate Medical Director will have professional and corporate responsibility for Primary Care.
Number of Posts	1 Post (Existing fully funded)
Areas of Responsibility	• Primary Care
PA Allocation	3 PA
Appointment Term	3 Years initially

13.4 Clinical Directors (24 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for services as directed within their divisional structures
Number of Posts	24 Posts (All existing fully funded)
Areas of Responsibility	• Assigned as per existing AMD Structure • New Clinical Director post for Research and Development • Reinstatement of Clinical Director roles (x2) for Emergency Department previously funded
PA Allocation	1PA per post (2 PA's for Research and Development post)
Appointment Term	3 Years Initially

13.5 Lead Clinicians

Role Description	**Lead Clinicians for Governance (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Governance
PA Allocation	PA cost to be agreed and funded by responsible operational directorate

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Appointment Term	2 years initially

13.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts
Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	3 Years Initially

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13.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning, • Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	3 Years Initially

13.8 Patient Safety Leads (Morbidity and Mortality Chairpersons) (19 Posts Total)

Role Description	**Patient Safety Leads (Incorporating Morbidity and Mortality Chairs) (Per speciality basis, as identified by Operational management)** Patient Safety Leads chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework

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	• Determine, support and develop appropriate patient safety inputs to the meeting • Ensure and monitor the appropriate multi-disciplinary attendance by all relevant professional groups. • Monitoring timely completion of screening templates and sign-off on NIECR • Monitoring of medical staff participation in Case Presentation • Ensure speciality meetings identify outcomes and sharing learning
Number of Posts	19 Posts (6 existing fully funded)
Areas of Responsibility	• DHH Medicine Chair (1PA) • CAH Medicine Chair (1PA) • Trustwide Surgery Chair (1PA) • Trustwide CYPS Chair (1PA) • Trustwide IMWH Chair (1PA) • Trustwide MHLD Chair (1PA) 13 Speciality Lead posts (0.5PA per post)
PA Allocation	(0.5 - 1 PA per post, depending on volume)
Appointment Term	3 Years Initially

13.9 Clinical Standards and Audit Lead (1 Post Total)

Role Description	**Clinical Standards and Audit Lead** The Clinical Standards and Audit Lead will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies. This role will include brokering actions across divisions and directorates where standards span same. This role will not remove or undermine operational DMD clinical governance responsibilities and accountabilities to their areas of service.
Number of Posts	1 Post (Previously Funded)
Areas of Responsibility	• Provide independent assessment of action taken to ensure compliance on a range of standards, guidelines and review recommendations

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	• Identify and challenge where compliance is not being achieved and lead discussions on how to improve compliance • Monitor the effectiveness of agreed action on compliance and take appropriate action to ensure clinical leadership is applied to address improved outcomes • Lead on the co-ordination of compliance discussions / actions across directorate interface areas
PA Allocation	1 PA
Appointment Term	3 Years Initially

13.10 Medical Lead for Coroners Services (1 Post Total)

Role Description	**Medical Lead for Coroners Services** The Medical Lead for Coroners Services will work with the Legal Services Manager Clinical Directors to provide professional and clinical input into the management of Coroner's cases.
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Coroner's Office and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Coroner's Office. • Provide, with the Legal Services Manager, a direct liaison and efficient communication with the Coroner's Office. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Coroner's Court which may mean attending that Court.

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PA Allocation	(3 PA, not funded)
Appointment Term	3 Years Initially

13.11 Medical Lead for Litigation Services (1 Post Total)

Role Description	**Medical Lead for Litigation Services**
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Courts and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Courts. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Court which may mean attending that Court.
PA Allocation	(1 PA, not funded)
Appointment Term	3 Years Initially

13.12 Clinical Governance Leads and Safety and Quality Improvement Leads

39. Each directorate will have the opportunity to develop Clinical Governance Lead and Safety and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

13.13 Administrative and Clerical Support Requirements

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40. To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Chair Of Division Support	Allocated within each directorate	Allocated within each directorate
Clinical Director Support	Allocated within each directorate	Allocated within each directorate
Lead Clinician Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

14. Proposal Costings

41. The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's), Infection Prevention and Control (2 PA's) and Standard and Guidelines (1 PA) were stood down and the duties merged into operational AMD roles.

42. The following costings for the revised medical leadership structure are as follows:

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
Medical Executive Posts	Deputy Medical Director – Governance , Patient Safety & Quality Improvement	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Workforce Development	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Professional and Workforce Development	4	2.5	1.5	
Operational Chair Of Division Posts	COD Surgery and Elective Care	3	0.79	2.21	
	COD ATICS	2	2	0	
	COD Medicine	4	4	0	
	COD Integrated Maternity and Women's Health	2.85	2.85	0	
	COD Children's and Young Peoples Services	3	3	0	
	COD Mental Health and Learning Disability	2	2	0	

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	COD Cancer and Clinical Services	3	3	0	
	COD Unscheduled Care &Emergency Medicine	3	3	0	
	COD Older People	3	3	0	
Corporate Services	CD Research and Development	2	2	0	*Post converted to Clinical Director Role*
	AMD Primary Care	3	3	0	
	Medical Lead for Coroner Services	1	0	1	*New Post currently unfunded*
	Medical Lead for Standards and Guidelines	1	0	1	*New Post currently unfunded*
	Medical Lead for Litigation	1	0	1	*New Post currently unfunded*
Revalidation Support	Medical Lead Corporate Appraisal & Revalidation	1	1	0	
	Medical Lead Consultant Appraisal & Revalidation	1	1	0	
	Lead SAS Doctors Appraisal and Revalidation	2	2	0	*Two Existing Funded Posts*
Patient Safety Leads	Patient Safety Leads (19 posts)	12.5	6	6.5	*Six posts Trustwide (6.5 new PA to include sub speciality M&M meetings)*
Total		**66.35**	**51.14**	**15.21**	

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
New Operational Clinical Director Posts	Clinical Director Posts Emergency Care (DHH and CAH)*	2	2	0	*Two previously funded posts*
Total		**2**	**2**	**0**	

**As of March 2020 one post has currently been recruited*

43. The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1WTE Band 4)	0 WTE	1WTE

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15. Proposed Service Enhancements and Accountabilities

15.1 Service Enhancements (Measurable Outcomes)

44. Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

45. At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline	• Responsibility for providing assurance on Trust Standard and Guideline processes

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processes and outputs	and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Learning from Experience functions	• Responsibility for the oversight and implementation of the Trust Learning from Experience function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff

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	feedback and M & M learning. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Learning from Experience processes
Strengthened support for Trust Safety & Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

15.2 Integration with Operational Management Roles

46. It is proposed the following collective forums will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

Type of Interface	Name	Composition
Corporate Interfaces & Collective Forums	Senior Leaders Forum	Trust Directors, AMDs and CDs (Bi-monthly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Weekly /

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		Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Forums	Directorate Governance Meetings	Directorate SMT Meetings (Fortnightly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

16. SMT Endorsement

47. The Medical Director asks the Senior Management Team to consider the previously set out proposal and approve its implementation

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Appendix 1 - Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trust's most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[25] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each

[25] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

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		service area
Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

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Appendix 2 - Review Process

Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

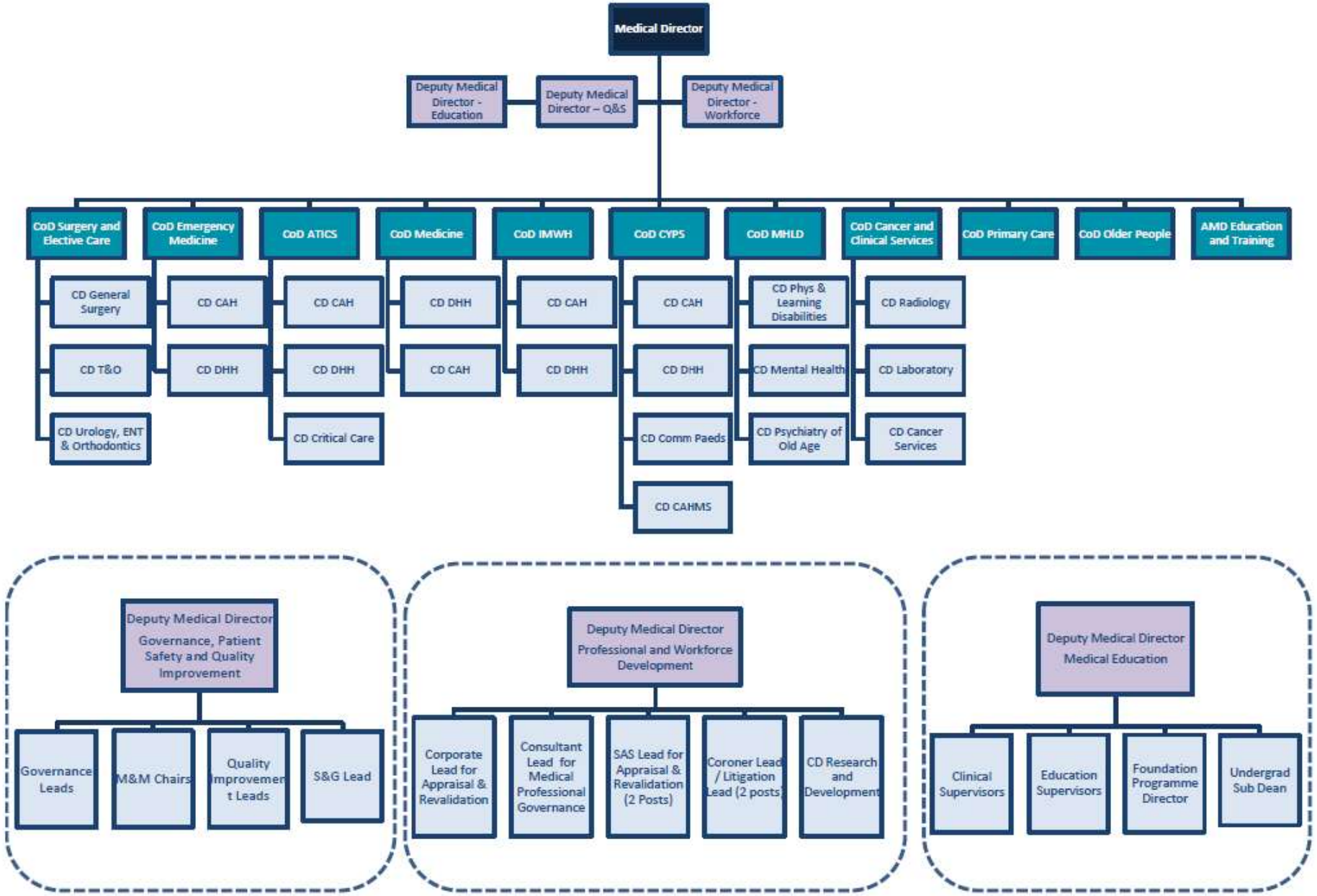
The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[26] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	2018 /2019
3	**Development of a Proposal Paper for Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	May 2019
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Quarter 2 2019

[26] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

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Appendix 3 – Proposed Revised Medical Leadership Structure



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Appendix 4 –Consultation with Trust Senior Staff

How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Clarity re role and responsibility for medical leaders vs operational managers, need clear guidance

- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A Learning from Experience MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas
- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.

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- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

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Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 9th November 2021
Title:	Medical Leadership Development Update
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Discussion / Approval

Overview:

Update on previously presented proposal (March 2021) on strengthening the Trust Medical and Collective Leadership Model which commenced with reconfiguration of the roles Associate Medical Directors and Corporate Associate Medical Directors. This paper includes details and costings associated with the Proposed Clinical Director structure.

Key Issues / Risks for SMT Consideration:

- Consideration of current medical leadership structures and previously funded medical leadership roles
- Approval of reconfigured Clinical Director role template and provision of funds required to move to position appointments.

Outcome of SMT Discussion:

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Background and Context

1. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation[1].

2. Leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice and also Management for Doctors.

3. While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes.

4. Doctors have a legal duty broader than any other health professional and therefore have a key leadership role within healthcare services. They have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction.

5. Learning from the Paterson Inquiry and expected themes from the Belfast Health and Social Care Trust Neurology Inquiry highlight the requirements for robust medical management structures to quality assure, professionally manage and provide safe effective care and services for our patients and service users. The Trust's upcoming Trust Public Inquiry regarding a Trust Urology Consultant will likely consider Trust Medical Professional and Clinical governance arrangements.

6. In 2019 the Trust Medical Director commissioned a review of the Medical Leadership with a view to a stronger collective leadership model to aid the creation of a Trust integrated, collective network of leaders distributed throughout the organisation who embody shared values and practices.

7. The report entitled "Medical Leadership Review" identified key medical leadership positions that are required to develop medical and collective leadership within the organisation. To date two Deputy Medical Directors and eight Divisional Medical Directors have been appointed.

[1] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*

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8. As the next stage of this process, the Trust Medical Director has now reviewed the Clinical Director role and revised the responsibilities of this role (Role description found in Appendix 2)

9. Each of these posts will have a clearly defined medical lead responsibility within the Division on the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance activity in partnership with operational managers.

10. The posts as configured will attract a 2 PA allocation as opposed to the 1 PA currently assigned. This is in recognition for the additional time required that by and large is undertaken in a supernumerary fashion by current post holders.

Rationale for Change of Clinical Director Posts

Expansion of Role and Responsibilities of the Clinical Director

11. The role and responsibilities of Clinical Directors has significantly expanded over the last decade. The modern Clinical Director role is now formally two-fold entailing a broad range of general management and leadership activities combined with the responsibility to deliver on clinical governance and patient safety within their divisional areas.

12. These duties have grown in excess of the 1 PA that was historically allocated. To full itemised range of responsibilities for modern Clinical Directors is set out in the role specification below:

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance within their areas of responsibility including:

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

Expansion of the Trust Medical Workforce

13. Over the last decade the Trust has experienced a significant expansion in medical staffing compliment while Clinical Director numbers have remained static. Since the inception of the SHSCT in 2007 to 2019/20. The table below illustrates this growth in substantive medical staff complement (excluding trainees, LATs, Long Term Locums, and Clinical Fellows).

Grade	2009	2021
Consultant	152	265
SAS / Staff Grade	64	110
Total	**216**	**375**

14. The table below provides information relating to the growth in the number of training grades from 2013 to 2021.

Grade	2013	2021
Training Grades	240	294

15. The increase in substantive medical staff complement is a 74% increase from 2007 to 2021 and an increase of 23% in trainee grades from 2013 to 2021. Despite this significant expansion in medical staffing the clinical director cohort and associated PA allocation has remained largely static.

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16. In addition to the above increases the Trust has commenced the roll out of a physical associate model. The Trust is currently growing the number of Physician Associates across specialities; to date there 10 Physician Associates employed within the Trust with plans to further expand this. The positions are also overseen and managed by the Clinical Director.

Increased Role of Medical Leaders in Professional Governance

17. The Professional Governance responsibilities on the medical workforce have increased significantly over the last number of years. Notably, since December 2012 the General Medical Council have required medical doctors to revalidate on a 5 yearly cycle. Medical Revalidation is a regulatory process and is intended to complement clinical governance, with the one strengthened by the other.

18. Clinical Directors are central to the local oversight of clinical governance for individual doctors. This clinical governance information both informs and assures Medical Appraisal and Revalidation processes. This change in the levels of responsibility for Clinical Directors has not been formally recognised through the time allocation allotted to the Clinical Director role.

Increased Use of Medical Locums

19. Medical locum usage has also increased significantly over the last number of years. As of 27th September 2021 there are 113 Long Term Locums within the Southern Trust. 60.18% (68 Locums) of Long Term Locums are engaged within Medicine and Unscheduled Care.

20. The General Medical Council states that '*some locums practice on the fringes of governance systems*' due to the nature of the locum role[2]. Oversight and management of locum positions presents significant challenges especially when it comes to delivering on professional and clinical governance activities.

21. Clinical Directors, particularly those in divisions that experience high volume of locum usage will require significant investment to ensure that a similar level of assurance that is sought from substantive post holders can be achieved for locum post holders.

[2] General Medical Council 2018 – What Our Data Tells Us About Locum Doctors 2018_04_11_locumDoctors_JG (gmc-uk.org)

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Number of Doctors Managed Per Clinical Director

22. There is significant variance in the number of doctors per Clinical Director in the Trust. Although a formal evidence base is not available for the ratio of Medical Staff per Clinical Manager by way of example in Craigavon Area Hospital Medicine and Unscheduled Care a single Clinical Director is responsible for the management and oversight of 59 doctors across a range of specialities.

23. In order to rationalise the number of medical staff each doctor is responsible for it is proposed that no clinical director is responsible for managing more than 30 substantive doctors. This number may be less dependent on a number of factors including speciality type and physical location of staff.

Clinical Director Proposal

24. The following three proposals are provided for SMT consideration:

1. **SMT agree the new Clinical Director role**
2. **SMT agree investment in 6 New Clinical Director Posts**
    - **2 Medicine,**
    - **1Unscheduled Care**
    - **1 Cardiology**
    - **1 Mental Health**
    - **1 Older Persons**
3. **SMT agrees the increase PA allocation for Clinical Directors to 2 PA from the existing 1 PA allocation and the associated costs**

25. An updated table on Medical Leadership Structures is provided below.

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Appendix 1 – Updated Proposed Divisional Medical Leadership Structures

Domain	Role	PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
Medical Executive Leaders	Deputy Medical Director – Workforce	6	6	0	*Yes*	
	Deputy Medical Director – Quality and Safety	6	6	0	*Yes*	
	Deputy Medical Director – Appraisal and Revalidation (24 months)	6	6*	0	*In progress*	**PI funding (24 months)*
	Director of Medical Education	4	4	0	*In progress*	*Currently covered by DMD Workforce*
Operational Divisional Medical Director Posts	DMD Surgery and Elective Care (Except Urology)	3	3	0	*In Progress*	*Being advertised currently via EOI process*
	DMD Urology Services	3	3*	0	*Yes*	**PI funding (24 months)*
	DMD ATICS	3	3	0	*Yes*	*Appointed*
	DMD Medicine and Unscheduled Care - Workforce	4	0	4	*Yes*	*Post realigned – Workforce and Governance split*
	DMD Medicine and Unscheduled Care - Governance	4	4	0	*Yes*	*Post realigned – Workforce and Governance split*
	DMD Integrated Maternity and Women's Health	3	3	0	*Yes*	
	DMD Cancer and Clinical Services	3	3	0	*In progress*	
	DMD Emergency Medicine & Unscheduled Care	3	3	0	*Yes*	
	DMD Children's and Young Peoples Services	3	3	0	*Yes*	
	DMD Mental Health and Learning Disability	3	2	1	*In progress*	
	DMD Older People	3	3	0	*Yes*	*Being met with OPPC funds*
Corporate Services	AMD Primary Care	4	4	0	*Yes*	*Two posts*
	AMD Infection Prevention and Control	3	3	0	*No*	*Previously Funded Position*
	AMD Research and Development	2	2	0	*Yes*	

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Domain	Role		PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
	Medical Lead for Coroner Services		0.5	0	0.5	*No*	*New Post currently unfunded*
	Medical Lead for Standards and Guidelines		1	1	0	*No*	*Previously Funded Position*
	Medical Lead for Litigation		0.5	0	0.5	*No*	*New Post currently unfunded*
	Medical Lead for Locums		4	0	4	*No*	*New Post currently unfunded*
	Medical Lead Complaints		1	0	1	*No*	*New Post currently unfunded*
	Medical Lead Wellbeing		1	0	1	*No*	*New Post currently unfunded*
Clinical Director Structure	Surgery and Elective Care	CD General Surgery CAH	2	1	1	*Yes*	*CD Leaving Post*
		CD General Surgery DHH	2	1	1	*No*	
		CD T&O	2	1	1	Yes	
		CD Urology, ENT and Orthodontics	2	1	1	*Yes*	
	Emergency Medicine	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*In progress*	*Incumbent now DMD*
		CD Unscheduled Care	2	0	2	*No*	
	ATICS	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
		CD ICU	2	1	1	*Yes*	
	Medicine	CD (3 Posts)	6	3	3	*1/3*	*Split governance and workforce roles cross sites*
		CD Cardiology	2	0	2	*Yes*	

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Domain	Role		PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
	IMWH	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
	CYPS	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
		CD Comm Paeds	2	1	1	*Yes*	
		CD CAMHS	2	1	1	*In progress*	*CD Appointed DMD*
	MHLD	CD Phys & Learning	2	1	1	*Yes*	
		CD Mental Health	2	1	1	*Yes*	
		CD Psychiatry Old Age	2	2	0	*In progress*	*To be funded by MHLD*
	Cancer Services	CD Radiology	2	1	1	*Yes*	
		CD Laboratory	2	1	1	*Yes*	
		CD Cancer Services	2	1	1	*Yes*	
	Older People	CD Older People Community	2	1	1	*No*	
		CD Older People Stroke and Acute Care	2	0	2	*No*	
Appraisal and Revalidation Support	Medical Lead Corporate Appraisal & Revalidation		2	1	1	*Yes*	
	Medical Lead Consultant Appraisal & Revalidation		2	1	1	*Yes*	
	Lead SAS Doctors Appraisal and Revalidation		2	1	1	*No*	*One post funded*
	Lead Medical Performance Management		2	0	2	*No*	
	Appraiser Allocation (0.25PA per 8 appraisals per annum)		5	0	5	*In progress*	*Agreed as per LNC discussions 2019*

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Domain	Role	PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
Patient Safety	M&M Chairs, 20 posts	13.5	6	7.5	*In progress*	*Six posts Trustwide (7.5 new PA to include sub speciality and increase in support for CAH Medical M&M meetings)*
	Divisional Patient Safety Leads (0.5 PA proposed per 50 doctors in division)	8	0	8	*In progress*	
	Clinical Audit Leads (0.5 PA proposed per 50 doctors in division)	8	0	8	*In progress*	
Total		**172.5**	**97**	**75.5**		

Costing Table (Total Costs)

Element	Number	Unit Cost	Total Cost
Total Required New PA Allocation Required (All Posts)	75.5	£9,200*	£694,600
Management Allowance(For New CD Posts)	6	£7,200)	£43,200
Total Cost			**£737,800**

**Midpoint of scale*

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Appendix 2 Clinical Director Job Description

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – XXXXXXXXXXXXX

DIRECTORATE: XXXXXXXXXXX

RESPONSIBLE TO: Divisional Medical Director XXXXXXXXXXXXX

ACCOUNTABLE TO: Medical Director

COMMITMENT: X PAs

LOCATION: XXXXXXXXXXX

Context:

The Clinical Director (CD) on behalf of the Divisional Medical Director (DivMD) will be a leader in Divisional Management Team. The CD will report to the DivMD and will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The CD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The CD will have delegated responsibility on behalf of the DivMD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

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Specialties / Areas Responsible For

- Specialty / Area 1 *e.g. Neurology*
- Specialty / Area 2 *e.g. Gastroenterology*

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance within their areas of responsibility including:

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

Specific Divisional Responsibilities

- X
- X
- X
- X

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within their areas of responsibility
- To promote quality improvement and to grow and embed a culture of Collective Leadership within their areas of responsibility
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within

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clinical and social care governance structures and culture.

- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

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Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of CD allocation.

Job Planning

- Provide leadership and support for Job planning process within their areas of responsibility for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and

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behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

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

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

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

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

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

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Section 2 – Proposed Medical Leadership Structure

11. Medical Leadership Development and Competence

36. A supplementary paper titled Medical Management and Leadership Development will follow.

12. Medical Leadership Appointments

37. It is proposed that if approved, all Medical Leadership management posts will be vacated and reappointed collectively.

38. This paper proposes that all senior medical leadership positions commencing from August 2019 are fixed-term appointments (details found in subdivision 14 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

13. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

13.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director position, responsible for providing assurance to Trust Board those effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services,

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	support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical and social care governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	WTE
Areas of Responsibility	Medical Professional Governance, Clinical and Social Care Governance, Medical Workforce Development, Patient Safety, Quality Improvement and Audit, Infection Prevention and Control
Appointment Term	Permanent Post

13.2 Deputy Medical Directors (3 Posts Total)

Role Description	**DMD – Professional and Workforce Development (New Post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	6 PA
Areas of	• Medical Appraisal & Revalidation

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Responsibility	• Job Planning • Medical Professional Governance • Oversight of Locum Doctors • Support and Oversight of International Recruitment • Medical Engagement and Recruitment • Coroner Services Oversight • Litigation Services Oversight • Oversight of Locum Management • Deputise Responsible Officer function for Medical Director
Appointment Term	Permanent

Role Description	**DMD Governance, Safety and Quality Improvement (New Post)** The Deputy Medical Director (Governance and Quality Improvement) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Clinical Leadership for Quality Improvement • Clinical Audit (National and Local inc. NCEPOD Ambassador) • Research and Development • Standards and Guideline Oversight • Infection Prevention and Control Oversight
PA Allocation	6 PA
Appointment Term	Permanent

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Role Description	**DMD Medical Education and Training (Existing Post Reconfigured)** The Deputy Medical Director (Medical Education and Training) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Undergraduate Education Leadership and Development • Postgraduate Education Leadership and Development • Physician Associate and Medical Associated Professions Governance • SAS Grade Leadership and Development
PA Allocation	4 PA (Currently funded at 2.5 PA)
Appointment Term	Permanent

13.3 Chairs of Division (9 Posts Total)

Role Description	**Chairs of Division (Operational Services)**
Number of Posts	9 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine • OPCC • Emergency & Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services
PA Allocation	PA between 2 and 4
Appointment Term	3 Years Initially

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Role Description	**Associate Medical Director – General Practice** Associate Medical Director will have professional and corporate responsibility for Primary Care.
Number of Posts	1 Post (Existing fully funded)
Areas of Responsibility	• Primary Care
PA Allocation	3 PA
Appointment Term	3 Years initially

13.4 Clinical Directors (24 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for services as directed within their divisional structures
Number of Posts	24 Posts (All existing fully funded)
Areas of Responsibility	• Assigned as per existing AMD Structure • New Clinical Director post for Research and Development • Reinstatement of Clinical Director roles (x2) for Emergency Department previously funded
PA Allocation	1PA per post (2 PA's for Research and Development post)
Appointment Term	3 Years Initially

13.5 Lead Clinicians

Role Description	**Lead Clinicians for Governance (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Governance
PA Allocation	PA cost to be agreed and funded by responsible operational directorate

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improvement on the Clinical Director's side. Could you summarise for us where that got to in terms of resourcing and in terms of numbers?

A. So there was - and the increased numbers was in recognition of having a wider spread of opportunities for medical leadership to develop, but also to share the workload, because the balance in all of this is always between the managerial time and the clinical time and, you know, from a service point of view we were very mindful that we did not want to strip out clinical expertise but we did need to bolster all of this. 10:41 10:41

So in relation to the different directorates, we went down each one individually and then increased the number of Divisional Medical Directors who were aligned to that and, you know, that has resulted in two in surgery. At a point in time there were two in medicine. We increased those then in relation to where that sat with bigger numbers of Clinical Directors then to support. So, for example, in Mental Health and Disability there continued to be an Associate Medical Director now replaced by a Divisional Medical Director, but instead of having one Clinical Director we now have three. So depending on what the needs were across each individual directorate the proposals were put forward in relation to that. 10:41 10:42 10:42

And then in relation to the Deputy Medical Director

posts, it was also about creating the opportunity for support to the Medical Director's office, but also having, you know, greater expertise and breadth and depth in terms of workforce and education, governance, and then more latterly appraisal, job planning and re-validation. So it was about bringing those elements together.

35 Q. Yes. And in terms of the problem which you observed, and which is highlighted in the survey evidence, how was the problem of relating to or integrating with the operational management, the director level staff, resolved, if at all?

A. There was - and certainly since I have become Chief Executive there has been an increased emphasis on Directors and Divisional Assistant Directors working with the Divisional Medical Directors and the Clinical Directors. So, you know, when we - in the past if there had been accountability meetings, the doctors weren't brought along to those. Now I have the expectation that they will be there, the same as everybody else, to take part. The same whenever there is oversight of certain situations or we need development in relation to certain areas. I certainly come to that, as do the Directors increasingly, that medical staff will be involved. So I think that culture of involvement has changed, but I do think it is still onerous for the doctors who undertake medical leadership roles, because they are still undertaking clinical responsibilities at the same time as they do

this and it is challenging, because part of the, you know, part of this role is in professionally managing their colleagues as well as contributing to the wider Trust, so there are a lot of demands made on their time. 10:44

I think - could I just say? I mean I think fundamentally medicine does not serve itself well in this respect. There is very little - when I look, for example, in comparison with the veterinary medicine 10:45 course across the UK, there's time and effort put into the development of leaders and, you know, an understanding of the business, and I appreciate that they're all - by and large veterinary medicine is a small business. 10:45

There's a lot - there's almost a third of the course in some areas put into developing leadership, you know, business acumen, all of that. We don't do that in medicine right from the point of medical student, and 10:45 the GMC at this point doesn't recognise medical management and leadership as something that merits a completion of specialist training. And, again, I think if those kind of supports were in the system right from the get-go, I think we would probably find it would be 10:45 much more straightforward then for people to be able to do these jobs, you know, more easily.

36 Q. There are a number of tensions, and the Southern Trust is undoubtedly not alone in this. You reflect that it

governance and, again, there were some fairly robust conversations in there in terms of changing this model. Now, this is now in place.

166 Q. Yes. Could I just maybe assist your answer by looking at the proposed structure as it appeared in this paper? 14:43

A. Yeah.

167 Q. It's WIT-47279. And as you were explaining, I think that operational management was going to shift to the Medical Director's office?

A. Mm-hmm. 14:43

168 Q. Albeit that operational managers would continue to retain responsibility...

A. Yep.

169 Q. - for commissioning governance activity, so that the benefits of local knowledge wouldn't be lost to the 14:43 system. But the important thing was to ensure that there was a better corporate oversight of governance issues and that nothing was lost in a silo?

A. Yes. Yeah. Yeah.

170 Q. Does that - no doubt as this made its way through the 14:44 system there were no doubt tweaks and changes along the way, but does that principle, as I've articulated it, is that what you were able to deliver?

A. Yes. Now we're in the process - the Acute Directorate that's on that diagram on the extreme left-hand side 14:44 then, after I became Chief Executive, I think as I mentioned earlier we split that in two.

171 Q. Yes.

A. So that meant that there had to be further governance

development in there. So bit by bit we have been building up governance teams in underneath those two new structures. But, again, you know, having them work as a team with the rest of the system. And I think what I can see from that is, you know, where we have the other three directorates - and OPPC is now called Adult Community Services Directorate, that's ACSD - what I can see where those are longer established and have been more familiarised with the model, their approach is more mature than the other two directorates, but that that is work in progress and they're certainly building on that. 14:44 14:45

I think to give me some assurance that this is working in the way that we proposed, we've done some work looking at a review of the operational governance under each directorate structure to see how it works, and there have been - there has been significant learning that has come out of that, and in recent times the discussion with the central governance function has been about how they then build on some of the examples that are there. So you, you know, for example, in CYP they have a really excellent manual that shows how governance is delivered within a directorate, so the other directorates are now replicating that. Mental health, again in terms of its learning from the early learning events, again that's been replicated now across the piece in relation to that. And then one of the other areas that we have introduced to all of these 14:45 14:45 14:46

Managing Low Level Concerns Training Record

Mandatory for all Clinical Directors, Clinical Leads and Operational Assistant Directors. Training required every 3 years

Last updated 17/01/2024

Name	Role	Date trained	Renewal Date	Certificate issued	Notes
Dr Andrew Knox	Clinical Director Obstetrics & Gynaecology CAH	02/05/2023	02/05/2026	Y	
Dr Aiden Cullen	Clinical Director Anaesthetics (DHH)	18/04/2023	18/04/2026	Y	
Dr Chris Clarke	Clinical Director ICU	02/05/2023	02/05/2026	Y	
Mr Adrian Neill	Clinical Director General Surgery	02/05/2023	02/05/2026	Y	
Dr James Hughes	Clinical Director Community Paediatrics	02/05/2023	02/05/2026	Y	
Dr Philip Quinn	Clincial Director Acute Paediatrics (CAH)	18/04/2023	18/04/2026	Y	
Dr Aisling Diamond	Deputy Medical Director Workforce and Education	18/04/2023	18/04/2026	Y	
Dr David Mawhinney	Clinical Director Emergency Medicine DHH	02/05/2023	02/05/2026	Y	
Dr Una Bradley	Clinical Director Medicine CAH (Acute Med /Gastro / Gmed / Respiratory / Diab & Endo	02/05/2023	02/05/2026	Y	
Dr Gareth Hampton	DMD Emergency Medicine & Unscheduled Care	02/05/2023	02/05/2026	Y	
Dr Rose McCullagh (AMD)	AMD Primary Care	02/05/2023	02/05/2026	Y	
Dr Damian Scullion	Deputy Medical Director Appraisal and Revalidation	18/04/2023	18/04/2026	Y	
Caroline Keown	AD of Integrated Maternity and Women's Health	02/05/2023	02/05/2026	Y	
Mary Burke	AD of Unscheduled Care	18/04/2023	18/04/2026	Y	
Julie McConville	AD of Specialist Child Health & Disability	02/05/2023	02/05/2026	Y	
Amie Nelson	HOS General & Oral Surgery, Breast and Endoscopy	02/05/2023	02/05/2026	Y	
Denise Newell	Head of Diagnostics	18/04/2023	18/04/2026	Y	
Wendy Clarke	Head of Midwifery & Gynaecology	02/05/2023	02/05/2026	Y	
Bernie McGibbon	Head of Acute Paediatric Services	02/05/2023	02/05/2026	Y	
Joan McMahon	Head of Community Paediatrics	02/05/2023	02/05/2026	Y	
Denise Carroll	Head of CAMHS/Autism	02/05/2023	02/05/2026	Y	
Ashley Craig	Consultant DHH	02/05/2023	02/05/2026	Y	
Bronagh McGleenon		02/05/2023	02/05/2026	Y	
Edgar Boggs	O&G Consultant	02/05/2023	02/05/2026	Y	
Janine Redmond	Medical Manager - Paeds	02/05/2023	02/05/2026	Y	
Kieran O'Connor	Anaesthetic Consultant	02/05/2023	02/05/2026	Y	
Rosemary Sloan	Clinical Lead Urgent Care Service Southern Trust	02/05/2023	02/05/2026	Y	
Karen Walker	Head of Urgent Care Service Southern Trust (GP)	02/05/2023	02/05/2026	Y	
Kerrie Smyth	Respiratory Physiologist DHH	02/05/2023	02/05/2026	Y	
David Grier	Paeds Consultant	18/04/2023	18/04/2026	Y	
Donna Muckian	CD DHH MED	18/04/2023	18/04/2026	Y	

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

Edel O'Neill	Consultant	18/04/2023	18/04/2026	Y	
Jayne McAuley	Palliative Care Consultant	18/04/2023	18/04/2026	Y	
Robin Brown	Consultant DHH	18/04/2023	18/04/2026	Y	
Shane Moan	Respiratory Consultant DHH	18/04/2023	18/04/2026	Y	
Shiva Arava	Specialist Reg Anaesthetics	18/04/2023	18/04/2026	Y	
Elaine Mulligan	Head of Specialist Primary Care Services	18/04/2023	18/04/2026	Y	
Nicola O'Reilly	Medical HR Case Manager	18/04/2023	18/04/2026	Y	
Rachelle Moore	Research & Development Manager	18/04/2023	18/04/2026	Y	
Simon Gibson	AD Medical Education & Workforce	18/04/2023	18/04/2026	Y	
Tracey Woods	Medical HR Manager	18/04/2023	18/04/2026	Y	
Dr Tanmoy Chakrabarty	Clinical Director Acute Paediatrics (DHH)	28/11/2023	28/11/2026	Y	
Dr Jonathan Boyd	Clinical Director Community Paediatrics	28/11/2023	28/11/2026	Y	
Dr Erskine Holmes	Clinical Director Emergency Medicine CAH	28/11/2023	28/11/2026	Y	
Dr Pat McCaffrey	DMD Older People Services	28/11/2023	28/11/2026	Y	
Sharon Holmes	HOS AMU, Ambulatory, DAU & Patient Flow	28/11/2023	28/11/2026	Y	
Paul Smyth	Acting HOS Emergency Department, Minor Injuries	28/11/2023	28/11/2026	Y	
Brigid Collins	EM Consultant	28/11/2023	28/11/2026	Y	
Ruth Spedding	Consultant DHH	28/11/2023	28/11/2026	Y	
Cheryl Gaston	ED Consultant	28/11/2023	28/11/2026	Y	
Declan Keenan	AMU Consultant	28/11/2023	28/11/2026	Y	
Aaron Ervine	Consultant Histopathologist	28/11/2023	28/11/2026	Y	
Lynda Magowan	ED Consultant	28/11/2023	28/11/2026	Y	
Elaine Campbell	Quality Nurse Lead	28/11/2023	28/11/2026	Y	
John Simpson	Independent SAI Chair	28/11/2023	28/11/2026	Y	
Grace Hamilton	AD Nursing, Safety, Quality and Patient Experience	28/11/2023	28/11/2026	Y	
Maggie Davison	Senior Revalidation & Appraisal Manager (Medical & Nursing)	28/11/2023	28/11/2026	Y	
Alice O'Neill	Consultant Anaesthetist	28/11/2023	28/11/2026	Y	
Siobhan Hynds	Deputy Director of HR Services	28/11/2023	28/11/2026	Y	

holders themselves or those who they were supposed to manage?

A. I think both. I think that, you know, traditionally - and I think it has now changed, I think over the years there was an ambivalent attitude by medical staff towards medical management because, you know, away back in the early days it was seen as a dark art. I think that has progressed and improved, and I do think that people within medicine really do value that now. 10:28

23 Q. Mmm. 10:28

A. But, also, I think there was an ambivalent attitude towards medical management across the organisation in relation to managers who felt, you know, the sense - and I think this was, you know, part of the culture, that the doctors were there to see the patients and get on with it and actually all the management decisions should be left to other people. I think, and again I think that point that's made in 8 summaries is this, the point in having a collective approach to this is to bring, you know, the expertise and the knowledge and skills all together in the one place across the different disciplines, and I am very firmly of the view that doctors should be leaders in all of that. 10:29 10:29

So, on the back of this report in 2020, what we did was revised - the job descriptions as Clinical Director and Associate Medical Director did not lend themselves to supporting the medical leadership that was needed. So we, you know, we undertook a complete revision of all 10:29

Sixth Meeting of the External Reference Group

Date: Friday 29th September 2023 (10am – 2pm)

Venue: The Law Society Buildings, Victoria Street, Belfast, Northern Ireland.

Present:
Mary Hinds (Chair), Dr Maria O'Kane, Hugh McCaughey, Dr Simon Watson, Veryan Richards, Jane McKimm, Robbie Pearson, Heather Trouton, Vivienne Toal, Maria Siahaan (Secretariat).
Apologies: Margaret O'Hagan and Tom Frawley

Welcome :

Mary Hinds advised the meeting that in the absence of Tom Frawley it had been agreed that she would chair the meeting.

1.0 Apologies

The Chair opened the meeting by thanking everyone for attending. The Chair advised the meeting that she received apologies from Margaret O'Hagan and Tom Frawley, and noted that Hugh McCaughey will be joining online via Microsoft Teams.

2.0 Update from the Trust Board Meeting

Dr O'Kane thanked Vivienne Toal and Hugh McCaughey for their work on the Presentation for the Trust Board meeting. She believed that the information contained in the Presentation had "landed" very well with the Trust Board members. Vivienne Toal then elaborated on the critical areas covered in Dr O'Kane's Presentation to the Board.

- Dr O'Kane opened the Presentation by advising the Trust Board that on 15th September 2023, she would have been fulfilling the role of Chief Executive of the

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

Southern Trust for 16 months. She then shared her experience and reflections on a range of examples from the "thousands" of episodes of care and interactions with patients and service users that have been delivered by staff during that time which she believed demonstrated both compassion and sensitivity. She emphasised that this in her view would represented the normal experience for patients in received of care from the Southern Trust.

- Dr O'Kane also highlighted some of the positive stories and compliments received through the Care Opinion portal. Some of the feedback she explained was related to the services provided by Obstetrics and also there were a number of examples from the Steps to Wellness Programme.
- Dr O'Kane had then updated the Trust Board on a range of awards that have been received by Southern Trust staff and services in recent months from external bodies. Examples she referred to included the outstanding success of Trust staff at the Royal College of Nursing NI Awards where the Southern Trust had received three first place awards and three runners up awards. She continued that The Trauma and Orthopaedic Service had recently received national recognition for the high quality information it provides to perspective patients in relation to joint replacement surgery. Craigavon Area Hospital had been placed within the 10 units that had been highly commended for their Professional Development, Obstetric training and overall performance.

- Apart from these outstanding achievements, Dr O'Kane had also explained that it was important to be aware that this award has been achieved against the backdrop of dealing with significant challenges that were affecting the Trust including negative publicity, industrial action and difficult staffing shortages.
- Dr O'Kane acknowledged in her Presentation, that the commencement of the Urology Services Public Inquiry in November 2020 represented a low point in the organisational life of the Southern Trust. Dr O'Kane explained that regrettably the well-being and safe care of Urology patients had not been given the priority it should have been.
- It is now essential that we demonstrate that these issues were being reviewed, identified and proactively addressed. It is for this reason she believed that the Inquiry presents an opportunity as well as a challenge for the Trust.
- In continuing her commentary Mrs Toal continued that Dr O'Kane also advised the Trust Board that she had commissioned an Independent Review of the "turnover" of General Physicians in Daisy Hill Hospital. Dr O'Kane advised the Board that it was clear from the completed review that the absence of a Strategic Plan to transform services at Daisy Hill Hospital was a significant factor in informing the decision of a number of the consultants to leave the hospital. She said that Dr O'Kane had advised the Trust Board that she now intended to share the findings of the review directly with the Consultants at Daisy Hill Hospital.

- Vivienne further advised that Dr O'Kane had indicated to the Board that the Findings contained in the Staff Survey platform would also be shared with everyone affected by the potential action that would now be developed from the insights emerging from the survey. Vivienne explained to the Meeting that there were three Questions contained in the Staff Survey, which she believed were particularly important for the meeting to note.

  1. Is the care of the Patients and Service Users in my Organisation its top priority?
  2. Would I recommend my organisation as a place to work?
  3. Would you be happy for your friend or relative to receive care in this Trust?

  Vivienne explained that Dr OKane had indicated to the Trust Board in her Presentation that the graphic charts contained in the Survey Report reflected that the staff responses to these questions (percentages) are slightly under the NI HSC average.

- Vivienne shared with the meeting the Findings from the Culture and Leadership Sub Group which Dr O'Kane had shared with the Trust Board. She explained that the Findings were derived from the meeting between the Senior Leadership Team (SLT) and a number of staff. The staff Dr O'Kane had explained to the Board, reflected that the Southern Trust needed to "draw a line in the sand" in relation to this very difficult and challenging period. The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build

such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust.

- Vivienne continuing with her account of Dr O'Kane's Presentation said that the Chief Executive had informed the Board that she had now asked Elaine Wilson the Director for Planning, Performance and Informatics to begin to draft a new Organisational Vision for the Trust that would be underpinned by a new 5 years Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately. She said that Dr O'Kane had emphasised to the Board that we needed to commit leadership to co-produce the Vision and Strategy by involving **all Stakeholders**.
- Vivienne advised the meeting that the Senior Leadership Team were now examining the development of the Principles that should inform how this important strand of work would be developed. She advised that in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
    - Safe and Quality Care
    - Investing our resources where they add most value

- A commitment to following through all actions that are agreed
- All underpinned by intelligent use of data

In closing her Report to the meeting Vivienne advised that Dr O'Kane had concluded her Presentation with the following two quotes:

"Those who cannot remember the past are condemned to repeat it."

"The first step towards getting somewhere is to decide that you are not going to stay where you are".

Reflecting on the Presentation, Vivienne said that she believed that the Presentation had been very impactful because it had been candid, open and honest. Robbie Pearson supporting this comment also reflected that the acknowledgement of past failures was very powerful. Both advised that in focusing on issues emerging from the Urology Public Inquiry there now had to be a clear commitment to Transparency and importantly that this commitment were evidenced in the Presentation. Robbie also suggested that the Leadership Team might consider including "Sustainability" as another important principle to be adopted by the Senior Leadership Team in moving these important issues forward. This was particularly relevant in light of the staff having expressed a clear view that the Senior Leadership Team needed to draw a line in the sand and move forward to a more hopeful future.

Dr Watson commenting that he believed the Urology Public Inquiry Proceedings had identified similarities and parallels with the other Inquiries that had been convened across

in NHS in recent years. He then advised that Healthcare Improvement Scotland (HIS) are currently investing in the development of an analytical tool to support management in the challenging task of ensuring greater safety of patients by identifying more reliable and sustainable approaches to ensuring safe care for all.

Action: Simon to share the Analytical framework with members

Hugh McCaughey said that he believed the Presentation was very well prepared and delivered. He said it provided a compelling narrative for the Trust Board membership. He believed there was a good balance in the information presented highlighting achievements while importantly acknowledging failures and ongoing challenges. He said it offered a very candid account while also demonstrating a clear commitment to improvement. He concluded his comments by suggesting that the most important audience for these messages beyond the Trust Board now are the staff working in the Trust. He said it was important to urgently deliver this message to staff but in doing so the leadership need to recognise the scale and the diversity of that audience. Therefore, he said it would be important to make the key messages more concise and accessible.

Dr O'Kane thanked the meeting for their comments and inputs. She said that through the Presentation she believed the Trust Board members had been given a candid and balanced account of the Key Issues that had been identified to date by the Inquiry and the resultant challenges that lay ahead. Concluding her remarks, she emphasised that there is still a great

deal of work to be done to reach a point in the Trust journey that the Senior Leadership now clearly aspired to.

Dr Watson responding to Dr O'Kane's reference to the essential change in the Trust Organisational culture that must be addressed was how leadership intended to effectively communicate a culture of "welcoming feedback" and "listening to staff" to critical behaviours that need to be established in the Trust if the culture change intended was to be achieved. As an example, he asked whether staff would have access to training session on how they might "speak up" or how to effectively articulate their concerns. Related to this critical behaviours he asked how can the Organisation be satisfied that at Senior and Middle Management Level that there is a commitment and ownership of these critical changes in behaviour.

In addition to this, he said that as part of the leadership challenge would be a commitment to demonstrate a capacity to listen importantly how would the management establish that we had the capacity and capability to be aware of what staff are communicating through the range of portals and opportunities available to them and then critically to demonstrate to staff that they had been heard?

Dr Watson advised the meeting that in HIS, they are currently working to develop a tool that would inform such judgements and evaluations.

Mary Hinds supported Dr Watson's comments said it is essential that we provide appropriate training that will enable those particularly in managerial roles to "**listen"** to staff.

Picking up on this point in relation to a change in organisational culture, Hugh McCaughey emphasised that it was vitally important to observe in management those characteristics that are evidenced not just, by what people say but also in how they act and conduct themselves. In this spirit, he shared with the meeting a quote that he had seen on the side of the Garrick building which he considered to be both inspiring and relevant for the leadership challenges that lay ahead.

"A nation that keeps an eye on the past is wise. A nation that keeps two eyes on the past is blind,"

3.0 Updates from Culture and Leadership Sub Group

- Identifying and agreeing the next steps for the ERG
- Developing and sharing the narrative that will be communicated to staff
- Developing and testing the engagement process that will be adopted in communicating with staff.

It was agreed that Vivienne Toal, Elaine Wilson and Hugh McCaughey should draft a map of a proposed engagement process. Vivienne also referred to the possibility of engaging with Trade Unions and the wider community of stakeholders as well as involving senior leaders (i.e. Band 7 above) in this critical process.

It was also important she said that the other Sub Groups were offered the opportunity to contribute to the testing and examination of the Engagement Process. Veryan Richards highlighted the importance of empowering staff at each Band/Level and not just more

"senior staff". She also indicated that we need to plan our engagement with staff at each level. Vivienne suggested that we can also consider establishing a new platform that might mirror the existing platform "Chat with the CEO" which would enable the Leadership to communicate as widely as possible the Trust's narrative to all staff.

Jane McKimm sharing an observation that she had developed through listening to the Public Inquiry Hearings said it was clear to her that frontline staff are the "heartbeat" of the organisation. She cited an example of a secretary at Band 4 having an extensive knowledge and understanding of each patient's treatment plans and therefore should be in a position to respond to non-medical queries from patients in an accessible way. In addition, she said a secretary could identify, if there are errors or inaccuracies within dictated "reports" from Consultants, secretaries could also identify gaps and faults in referrals for example. To this end, Jane expressed her view that it is very important for management to engage these frontline staff and make them feel "heard" and "valued" when they raise concerns or issues about their work with Supervisors.

Hugh McCaughey supported Jane's comments. He added that when staff feel they are being listened to, they would become real advocates by actively promoting the engagement plan.

Dr Watson elaborated on what he considered to be the real value of a listening organisation. In concluding his comments he said that there were key sources of critical information that we needed to focus on. In particular, he said there is a need for a much more sophisticated

approach to the analysis and interpretation of clinical data. He said that this was an area that would need an investment and expertise.

He also shared with the meeting who he believed were the critical audiences who must be engaged with if we were to be seen as authentic, these were:-

- the voice of patients
- the voice of the public
- the voice of staff

The plans for the culture and leadership group to meet with the quality and safety group had not materialised due to operational pressures.

Action: SLT to agree how they wish the coordination of sub group efforts to be taken forward

4.0 Updates from Analytics Sub Group

Dr Watson opening his report shared with the meeting the background to the analytical framework that is currently being developed by HIS. He continued his comments by quoting Robert Francis', the Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry who in his Executive Summary wrote: "The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent". Dr Watson said that this quote highlights the need to develop the processes and data that would offer a meaningful insight on how the implementation of recommendations

made by an Inquiry or Review were being proactively monitored. He explained that Steve Wilson from HIS is currently developing an analytical framework to identify "early warnings" of serious problems particularly in relation to the Quality and Safety of care.


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Leadership Diagram.docx


20211119 SIHCG analytical framework


SIHCG Framework.pdf

Dr Watson then took the meeting through the slides that he had prepared. In his Presentation, he explained that the analytic framework is divided into 7 categories (Leadership, Culture, Governance, Financial Performance, Workforce, Professional Engagement and Clinical and Care Performance). The framework he continued can provide quality assurance, offer reliable early signals that may identify areas of error, and provide the person responsible for reviewing them with material that can inform a detailed analysis of this information.

Concluding his comments, Dr Watson advised that he can facilitate contact with Steven Wilson should the Southern Trust wish to have further discussion about the Framework.

Dr O'Kane thanked Dr Watson for sharing the Framework. She said she found the framework very useful, she believed it could provide a helpful toolkit for the Board as it could offer early warning signs of potential risks and challenges. Dr O'Kane added that she would ask Elaine Wilson, Director of Planning, Performance and Informatics to contact Dr Watson on how this matter could be taken forward by the Trust.

Actions:

- **To map out a system of "triangulations" that would facilitate the analysis of data**
- **to take forward an initiative on Data Analytics**

6.0 Updates from Accountability and Governance Sub Group

Robbie Pearson opened his update by emphasizing that it was essential that the Trust adopt the Champion Report in relation to Governance. He advised that he intended that the Sub Group would engage with the SLT and the Trust Board in the near future. In addition to these steps, Robbie identified the need to build a Trust wide learning system and importantly to identify how this critical work would be supported going forward. He also said that it would be important to allocate a management resource to support this work stream.

Dr Watson also commented that the Trust should consider the option of developing a management trainee scheme or a graduate management trainee scheme. In addition to this, he suggested the group should support an initiative to establish capacity to undertake this work including a "route map" that would inform the implementation and the timeframes for the implementation of the plan. Vivienne responding said that the number of training places in management is very limited. Veryan Richards suggested that it would be very important to develop a timeline for the program that is achievable and to map out a timeline that is realistic.

Dr Watson alos comented that he felt it was important for the Trust to start addressing the issues identified now by the inquiry. Taking this two track appricah, looking to the futre while addressing issues of the past and present, would ensure the Trust are well prepared for the final report. This was supported by Jane and Heather who could see ow the inquiry were identifying practical issues that could be actioned before any final report.

Action:

- **Trust to consider a process addressing emerging issues.**
- **To identify a resource in the Trust that would be available to take the important work on a Accountability and Governance forward after the work of ERG is completed.**

7.0 Themes and Considerations for SLT- Veryan Richards


Part 4.0 Public Inquiry - notes and


STERG Themes and considerations for tl


Part 5.0 Public Inquiry - notes and


STERG Themes and considerations for t

Veryan began her Report by explaining to the meeting the themes that she had identified in reviewing the proceedings of the recent Hearings. She explained the themes contained in the Paper were in the following order: Leadership and Governance, Quality and Patient Safety, Culture and Behaviour and Communication.

1. **Leadership and Governance**

Training

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

"What is the SLT's view on Datix training being mandatory for all staff on the frontline?"

"Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?"

Page 10 Public Inquiry Hearings Day 42 – 49

"the importance of training to a good standard to all those involved in job planning and drawing up professional contracts"

"Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?"

Trust Improvement

Page 14, 15 and 16 Public Inquiry Hearings Day 50 - 57

"You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well. How can this narrative be reinforced throughout the Trust?"

"The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate. Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?"

"but the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have the families coming on board who were willing to influence the future was a really good piece of work. We have a statutory obligation,

actually, to involve patients' right from design, implementation and evaluation of all of our services."

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go through to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'.

What are the next steps to move towards this goal of inclusion, partnership and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'.

Page 18 Public Inquiry Hearings Day 42 – 49

"The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?"

2. **Quality and Patient Safe**

Page 20 Public Inquiry Hearings Day 50 - 57

"Post inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care."

3. **Culture and Behaviour**

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"how readily are patients in the Trust perceived by staff as being one of the main members of the care team?"

"an example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of learning culture."

"Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?"

4. Communication

none to note

8.0 Date of next meeting

The date of the next meeting was agreed for the 10th November 2023. It was also agreed that the meeting will be started at 9am in the Law Society NI to facilitate travel by those attending the meeting from Scotland. . It was felt that this may be the final or penultimate meeting of ERG, to be discussed with the Chair.

9.0 Any other Business

There was discussion within the group about preparation for ending of the formal ERG meetings circa the end of 2023. On behalf of the Trust Dr O'Kane agreed that a paper reflecting the learning to date and the approach to improvement would be presented by the Trust members to the other members of the ERG at the next meeting.

As there were no other business to be discussed the meeting then closed.

STERG – 29/09/2023 – agenda item

Suggested themes and considerations for the SLT – Days 50 - 57

The aim:

- to build public trust and confidence in patient safety and person-centred quality care
- to raise professional standards within the Trust
- to address and make provision for good staff wellbeing and morale.

Transcript notes and analysis

- to listen and identify some learning as the PI is in progress, to support Maria in helping her to keep in touch with the emerging themes and to assist the Trust in using this lens to consider modifying practice.

- to reassure the staff, patients and the public that the Trust is listening and is making efforts in real time to improve the standard of care for patients and raise the bar in terms of professional standards. Some of this intelligence gathering may already be happening within the Trust as well and it would be interesting to compare notes.

- we are not sure when the PI Report will be published with its conclusions and recommendations, in the meantime the Trust can be seen to be proactive.

STERG - the emerging themes from the PI transcripts.

- can strategy, practice and evaluation be considered in response and some guidance given on a possible route map for the next steps and potential medium-term goals?

(Note – please refer to the document Part 5.0 'Public Inquiry – notes and reflections' to give wider context to the points in the themes below. These papers have been circulate with 'Suggested themes and recommendations for the SLT')

THEMES

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

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1.Leadership and Governance

Tracking, clinical decision-making, and audit

Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers.

Q. I am talking more if you were asked what's the quality of clinical outcomes in Urology, would you have data to look at?

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

Q. I think that is what they said.

A. Yes.

Q. They said this is performance.

A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap.

Is the SLT happy that there is now a high standard of robust data to cover quality standards across all the specialities? If not, as a priority, what immediate steps can be taken to address this?

Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: "As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." I think you have mentioned some of those external barriers are buy-in from GPs, and you have also mentioned, I think, the Board as well?

A. Yes.

Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented.

Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

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A. Mm-hmm.

Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then.

Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed?

A. Yes.

Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes.

What are the current figures?

Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly?

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

Is the system for guidelines monitoring fit for purpose and regularly audited?

Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. Given that, the cancer tracking issue and the CNS issue, might the findings and recommendations from the nine SAIs more helpfully have provided systemic suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients?

A. Yes.

'Q There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.'

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Is it still the case that various parts of the system are struggling to deliver successful care pathway oversight?

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern

Does the SLT consider 'the missing clinical audit' an area of concern? If so, what are the steps to address this?

Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

When there are recurrent issues taking a deep-dive approach to them is important, sampling and auditing some of the work. 'Lift the stone and see what else is under it.'

Can the SLT identify any current recurring issues in the Trust where this approach needs to be applied?

Quorate

Job description, appraisal, and handover

Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in 9 June '19.

Q. So, the emphasis was on the immediate –

A. Yeah.

Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance?

A. No. Again, I believe that those were felt to be in hand at that point in time.

Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed.

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Q. Knowing what you know now, do you think that you should have been told?

A. Absolutely.

Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those.

As one of the learning points from this Inquiry - what measures are in place to ensure a full handover process is seen as a priority for people taking up a new post?

Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien

A. Yeah.

Q. -- to agree or disagree?

A. Yeah.

Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion?

A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.

Is it appropriate for the Director of Acute Services to sign off 'medical professional' job plans?

Trust Board

Silo mentality – segregation operationally as opposed to integrated working

A. Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

Q. "Better inclusion of non-clinical managers with clinical managers." You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

Is there now a good connecting structure in operation with non-clinical managers and clinical managers in all departments? Is this being monitored and where there are issues are they being addressed?

Priorities

Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that?

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A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known him, they would have phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

Good 'customer care' standards towards patients – should always be seen as a part of a deliverable care package and not an optional extra in healthcare. When was the last audit of this done in the Trust? What did the results show and what actions are planned as a result?

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that at the beginning.

Mapping the Inquiry recommendations with the recommendations of other recent reviews and SAI's will be one of the first steps post Inquiry. This will contribute to assisting the Trust in shaping a firmer foundation, develop streamlined action points as well as the important task of building confidence with the public in the delivery of good and safe patient care.

Training

Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but –

Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them.

Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training.

Q. So was it optional?

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A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives.

Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

What is the SLT's view on Datix training being mandatory for all staff on the frontline?

So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?

MHPS

Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality?

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people.

Confidentially vs intelligence and learning from the MHPS process – is there a guideline in place that addresses this? Does it need updating?

Oversight Group

Management

A.I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is

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inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive as a result of that, but that incident in 2019 just wasn't as clearcut as described there. With regard to the model within Acute, the model in the organisation for clinical and social care governance was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director and the Divisional Medical Director and their professional accountability line to the Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or made it difficult to get information.

From a governance perspective - are there currently clear pathways to allow the maximum information flow in all parts of the system?

Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management?

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

Have all the recommendations in the Clinical and Social Care Governance review been implemented?

Q. Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally?

A. Well, in many ways it was a holding to account relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some

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novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes.

Is this still the case?

A. But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system.

Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention.

A. Mm-hmm.

Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that?

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known through the Governance Coordinator where there was glitches in the system that we needed some action. When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit of momentum going within the Directorate.

Q. Those posts were filled before you left, were you?

A. Yeah.

Q. Were they two Band 5s?

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A. No, there was four. There was one for each division.

Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large –

A. Yeah.

Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it. We were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it.

'So, we would have known through the Governance Coordinator where there were glitches in the system that we needed some action'

With a band 5 now in place for each AD – are there any remaining 'glitches' that need addressing?

'Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it.'

Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: "The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation**.** It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one.

Q. In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason?

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in

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fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report

The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1."

Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes**.** I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you.

Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre.

Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a checklist of things to make sure they are done?

A. Absolutely.

Q. Would that be something that might assist?

A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted.

Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent?

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Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall?

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had designated tasks that the different people around, say, job planning or audit, whatever, would work through and develop with the groups. But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work.

Alongside the learning from the SAI's, there have been several significant reviews in the Trust in the last 10 years, each with recommendations. Added to this will be the recommendations of the Urology Public Inquiry Report.

Going forward:

- what are the plans to review and bring some clarity, standardisation, and consolidation to all these recommendations?

- then to move through to systematic action and implementation?

- what is the SLT's view of developing 'a toolkit for incidents'

Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it.

A. Mm-hmm.

Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting?

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a different way to do governance, I think, not just a series of tick box exercises.

How can the SLT shape the narrative post Inquiry so that this momentum can be maintained?

Q. Yes. Dr. Boyce has suggested that -- if we just pull up her statement, TRA-05849. If we just go to line 4, please. I'm asking her why you wouldn't take on this direct interfacing role with Trudy Reid, and you have given me an account this morning of why. Dr. Boyce's perspective on it was that you were overwhelmed with the post, it was a massive post, "and also there was maybe a level of inexperience in terms of governance, leading governance in a very big, very vast ranging Directorate." She says, "I think the fact that I was there and had already been doing it sort of allowed [you] not to maybe take it back fully." The downside of it, she explains, is that it made her nervous on your behalf because

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obviously: "Then Esther was going into Senior Management Team, the Corporate Governance meeting and so on, without that interface so I was always nervous about how she could then represent and talk about her risks and so on." Do you recognise that there was this risk of a gap if you weren't as fully committed to the governance aspects as Tracey Boyce says you ought to have been?

A -- So yes, I was uncomfortable and I felt extremely just unsupported in terms of -- you know, if you feel supported when you are in a swimming pool with rubber rings and everything and everybody takes that away, you feel a little bit adrift.

Are there any people in current senior leadership roles who are not carrying out their full brief?

'Q. The Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that'

Is this a trend that is still happening? If it is, how is it being addressed?

Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust?

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1" and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet**.** They hadn't the ownership.

It takes time for people to realise that governance is your business and somebody is not going to do it for you.

Is this understanding of governance widespread in the Trust today?

Trust Improvements

Q. Does that apply for the MHPS process as well?

A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people.

Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS?

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A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know.

Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level?

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question.

Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out?

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on.

'Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise.'

What is the current policy on sharing anonymised information and learning from MHPS/SAI's with the Governance Coordinator across Acute Services?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well.

'You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well'

'Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well'.

How can this narrative be reinforced throughout the Trust?

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Q. "I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential".

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything that would unblock that would probably be helpful?

A. Yes.

Q. Then you say at 22.6: "We should be an organisation with an effective corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring." The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate.

A. Mm-hmm.

Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again?

A. Yes. Yeah.

'The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate'

Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?

Q. You have said this previously but just to give you an opportunity to say anything else about it: "A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice". We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

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A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

'But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work'

'We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services'

'I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public'

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go though to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'

What are the next steps to move towards this goal of inclusion, partnership, and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'

Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct?

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus.

Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it.

Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah.

Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

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A. I think they are on that journey. I think they are starting to think even MDM outcomes for different specialties is part of that.

Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place.

'Clinical effectiveness and clinical audit and we need more of it. We don't actually have any measures of the clinical outcomes in specialties, for many specialties'

This is key information that is needed for quality and patient safety – can this audit process be embedded across all specialities with a timeline for action?

Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note.

'Q. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely'

Is the messaging clear throughout the Trust on the importance of documenting all decisions taken and circulating them to the relevant people?

Quality and patient safety

Q. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines?

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next.

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'Our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again.'

Can this idea of a trigger list being used as an audit tool be applied to other areas of clinical practice in the Trust?

Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with?

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward.

How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff?

Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered?

A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were.

Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of thatdate but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

'A. 'I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly'

Q. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?'

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What learning can be taken from this (and actions if needed) to ensure that the principle of assessment of the risk to patients is always paramount in clinical practice?

Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net?

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at.

Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that.

Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

Q. That's different from writing it, isn't it?

A. Yes, very.

This is an issue that has come up several times in the Inquiry – can the SLT clarify the guidance across the Trust on patients receiving letters after appointments recording their treatment discussions and plans?

Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair?

A. That would be fair, yes.

Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or

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and thinking it and saying it in a letter and then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

Q. I think Vivienne Toal said something similar. She said "His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin.

Post Inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

How operationally robust is the role of peer review and peer pressure in maintaining patient safety and quality standards throughout the Trust? How regularly is this audited?

3. Culture and behaviour

A. The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the the requirements for change tailored to each individual's practice.

A. You expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen

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by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that.

Are there any current areas in the Trust where there are difficulties in bringing about behaviour change?

A. I think the journey that we were on in terms of embedding the culture of if an incident occurs, recognise it as an incident, discuss it, report, let's learn from it.

Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's –

'The journey of opening the culture was a journey in progress' – post Inquiry, what does 'opening the culture' require at this stage?

- 'There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame.

- Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch...

- At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands.

- I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place

- Eamon Mackle told me they were drawing bets of how long I would last'

This narrative is now in the public domain and can be interpreted in several ways. How will the SLT address the themes that are raised in it on two fronts – for the staff in the Trust and for patients, carers, and the public interface?

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Q. Can I ask you this: Was it your sense that by the end of your time in the Acute Directorate, governance, in terms of its capacity and resourcing, was in a better place than what you found at the beginning, or was it treading water?

A. Ever so slightly. Every so -- well, we treaded water for a long time. It was ever so slightly better but, to be honest, whenever I left, anything was the last thing from my mind so I didn't even think about governance when I was going away. I was looking forward very much to working with Patricia Kingsnorth because she, to me, had exactly the same idea and I knew I could -- we could have -- and she was very proactive in Maternity. So, it was slightly better. Certainly the language that I used in my meetings about governance being important, and trying to bring on board. But, as I said to you before, you know, the culture was performance, performance, performance, and I don't know that I did very much to change that as an individual.

'The culture of the Southern Trust when I joined was performance, very much performance driven'

How would the SLT describe the current culture?

'There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so'

How can team working be enhanced in the Trust?

The biggest thing that was maybe just pie in the sky for me was changing the culture in relation to governance. Culture eats strategy for breakfast. If you are going to ask me what I learnt, that's the biggest thing.

'Culture eats strategy for breakfast'

Has the SLT adopted the priority of establishing a constructive and empowering cultural lens before delivering the detail of forthcoming strategy?

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as following up a procedure. I need to know what my role is but I also need to know what your role is so that we don't overlap or I don't do your job, causing conflict and concern. There was an awful lot of dissatisfaction in that. I believe it's because people didn't know what their roles and responsibilities were and they just did whatever they thought on the day.

Q. Where do you see the responsibility for fixing that as lying?

A. Well, whenever it's a culture, it's very, very, very difficult to fix. It would needed to have come corporately from the top on down. It would needed to have been -- you see, you can't make somebody do something unless they believe it's right to do. You know, me making people believe, from my very, very small part I discussed it, discussed the importance of -- and it's not even hierarchy, it is just communication lines. I didn't mind talking to whoever in the canteen or whatever, but as long as the information that needed to be passed up and down went through the proper lines.

Recognising the key role of good communication flow throughout the Trust as a tool in changing the culture.

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Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it?

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

‘I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?".

‘A. It demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities.’

Is the current messaging in the Trust consistent, empowering and across the board when it comes to the requirement of a clinician’s individual responsibility, accountability, and action?

Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

Q. And she makes the point in 3 and 4 -- this is page 10: "We are relying on people to do the right thing, which is the weakest safety net..." -- and she asks the question: "Did the team consider anything stronger in terms of making sure this didn't happen again?" So, for example, alerts for unread Radiology reports/ monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to

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accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah.

Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations?

A. Yeah.

'At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"?'

How is the SLT building this narrative into current culture?

Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians?

A. Yes.

Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them.

How is the SLT addressing the ongoing need to facilitate a culture within the Trust based on respect for the different roles and responsibilities of all employees in the Trust in the delivery of quality care and patient safety?

4. Communication

The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation.

Q. So visibility was a benefit in relationship building and confidence-building?

A. Very much so.

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What steps can the SLT suggest to encourage all members of the senior team to become more 'visible' and for the SLT to lead by example?

Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view.

Can this approach be applied to all future SAI's in the Trust?

'Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you'

One of the main ways of bringing people with you is to ensure there is quality and frequency of communication. Some thought needs to be given to this.

Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things.

A. Yeah.

Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in charge of it.

A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

Q. Yes.

A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care.

Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction?

A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes.

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Post Inquiry – it will be important to establish clear lines of communication for information flow and learning throughout the Trust. Also, to check that everyone has clearly defined roles and understands their responsibilities and accountability. Underpinning this will be the outlining of Trust values and principles and the strategic aims for the next five years.

Veryan Richards

16/9/2023

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

body or is it still lagging behind? Is there a funding issue for either the time or the development required?

A. I think, again I think it's patchy. I think some areas value it more than others, and where it is valued I can see it just, you know, produces a huge amount of value. 13:29

148 Q. DR. SWART: Yes.

A. But, you know, I think particularly in persuading some of the, you know, recently appointed consultants in particular to start to take on and develop these roles, I think that is a bit of a challenge, but we need to 13:30 have, you know, we need to have succession planning and thought and everything else into that. And, again, it's about, you know, how we support each Divisional Medical Director to grow their own community of leaders within each of the directives. 13:30

149 Q. DR. SWART: And have you got a fully developed development plan that's funded?

A. Not yet. No, not yes. And, again, that's part of the discussion that's been ongoing in relation to where do we get that help? So now that we, as I say, we're 13:30 about to appoint the latest recruits into that because of just turnover, I think, you know, part of the plan in relation to '24/'25 is to develop the whole medical leadership side of it.

150 Q. DR. SWART: Just taking that up to Board level. You've 13:30 got a very big Trust, you've got a lot of different disparate services. Do you have enough clinical input at Board level and/or in the senior leadership team? What's your view on the bandwidth that's covered?

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

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

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

Medical Professional Governance Improvements

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

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

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

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

Clinical and Social Care Improvements

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

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

Reference Number:

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Job Description

JOB SUMMARY

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for: medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

- To contribute strategically as a member of the Directorate Management Team
- To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.
- Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office
- To take responsibility for performance management including appraisal of designated clinicians
- To provide leadership to medical staff to enhance collaboration on Reform and Modernisation agenda

KEY RESULT AREAS:

Strategy Development:

- Contribute to strategy development as part of Directorate Senior Management Team.
- To advise the Management Team of Directorate priorities and pressures and contribute to the development of an Annual Directorate Management Plan and Trust Delivery Plan

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Service Delivery

- To function as a member of the Directorate management team with responsibility to contribute to strategic development and operational excellence.
- Provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the directorate
- Use the resources of the Directorate to deliver, in both quality and quantity, the activity and targets agreed for the Directorate
- To support the Trust in planning a response to major incidents and outbreaks.

Professional Leadership

- To develop and lead a team of Clinical Directors and Specialty Leads to assist the Trust in the redesign, modernisation and improvement of service delivery and ensure a senior professional clinical lead on the major Trust facilitiesl
- To identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate
- To ensure the highest standards of clinical effectiveness and medical practice in the Directorate, including the implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- Contribute as an effective member of Directorate Governance Committee
- To place Patient Safety at the centre of Directorate activity

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Medical Education and Research

- Be responsible for the delivery and development of Medical Education and Research within the Directorate

Leading the Medical Team

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives

- Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets

- Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.

- Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors

- Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.

- Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively

- Influence the modernisation of the workforce as systems for delivering care change

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

Quality & Information Management

- Support the development of clinical indicators and outcome measures relevant to the Directorate clinical specialities.

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- Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate

- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate

Collaborative Working

- Actively promote the development of clinical and professional networks across primary, secondary and social care.

- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated

- Promote and develop effective multi-professional team working and communication.

Corporate Responsibilities

- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Surgery/Elective Care works. Other duties of a similar nature and

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appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Acute Services.

GENERAL RESPONSIBILITIES

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

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

July 2007

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then when Ivan Stirling retired, consultant colleague, retired in 2006, then they needed somebody to do CD for Surgery and I was asked would I do that then. Then I was asked when the new Trust was being set up would I apply for the Associate Medical post. 10:49

MR. WOLFE KC: If we can look at your job description, the Associate Medical Director role. It's to be found at WIT-11836. I think the last page of that document, just for the Inquiry's note, will show that this is the job description as of July 2007, the year before you took up the role. 10:49

Sometimes job descriptions don't reflect, Mr. Mackle, I suppose the practical reality of what the job is about. Before we delve in, have a little look at some of the detail in the job description, what, in broad terms, was the job about? What did it require of you? What was at its core? 10:50

A. I suppose leadership and advice to management; advice to management how we could help develop the service. This was the start of the new Trust when we had combined with Daisy Hill. So, Craigavon Area Hospital Group Trust became the Southern Health and Social Services Trust. So it was that stage advising how we could work, how we could integrate, how we could develop the services. 10:50 10:50

One of the things ultimately involved in it was development of orthopaedic services, trauma and

Director, citing workload pressures and performing far in excess of what could be considered realistic or sustainable. Do you recall that?

A. Yes, I do.

48 Q. The reference, I don't need to bring it up, but just for the record, is TRU-163344. Just before I ask you the question. Ms. Gishkori has commented on your contribution as Associate Medical Director. If I could have up on the screen, please, WIT-23380, and focus on para 47 if you would for me, please. I'm sorry I don't have the question that prompts that answer, but I think we probably get a sense of what the question was. It was probably something to do with how she encountered staff in the team, and she says: 14:46 14:46 14:47

"Mark Haynes was the AMD for Urology. We were supposed to meet monthly, however he rarely attended scheduled meetings and he rarely attempted to make any informal contact with me. He was unable to provide time." 14:47

Is that fair comment?

A. As I say, I have reflected and commented that I would often not be able to attend meetings. The Acute Clinical Governance meeting, which was one of the meetings I have mentioned earlier in relation to SAIs, takes place on a Friday morning at the same time as I have an operating list in Belfast Trust which makes it very difficult for me, certainly made it very difficult for me to attend pre-Covid when video 14:47

MR. WOLFE KC: If you were to be given a blank sheet of paper to design a way of doing the role that we call Associate Medical Director, and taking into account the importance of that role within medical management, what would be the improvements you would write on that blank piece of paper in light of your experiences? 11:37

A. I think the biggest one is time, time to do the job and do the role. I think the disadvantage of that is you probably exclude anybody - particularly in surgical areas - who has part general and also some speciality from being a medical manager. But I do think that's -- if you have somebody who is a pure subspeciality, it may be easier for them to do it if they don't have a general role. But when you something like general surgery plus subspeciality, I think it is nigh impossible to have the time that you'd want for it. 11:38 11:38

Should it be almost 50/50? Probably should. Added to that, as you say then, I had significant support from the heads of service and the Assistant Director, and the Director. I was actively supported by them but they also had a significant operational role. There was no other role -- nobody supplied to support the associate medical directors in their role as Associate Medical Director, purely driving that forward. That didn't exist. There was nobody there who said -- you know, I think that's the big -- that area, I think, was missing, an active support for medical directors -- 11:38 11:38

or associate medical directors rather than just the operational support, which I appreciated and got a lot of.

MR. WOLFE KC: You didn't have formally any administrative support for the role? 11:39

A. No, no.

MR. WOLFE KC: Did you have any specific training for the role, or indeed for any of your managerial roles over the course of the 20 years?

A. I believe -- I don't remember the exact time but -- 11:39
I can't remember had I just become a CD in cancer services, I think I might have been, or I was a CD. I can't remember, it was around the time of the CD, I went on a CD manager course, which I think was six half days in Lisburn Council offices. I can't remember 11:40
exactly but it was up in Lisburn.

MR. WOLFE KC: Stating the obvious, you went to medical school, you didn't go to managerial school?

A. No, no.

MR. WOLFE KC: I don't mean that flippantly. 11:40
You didn't do a medical degree thinking I'm going to be a medical manager. Do you think in terms of all that goes with management - and this is a particular species of management, it is professional management, and we have seen what goes into the job description - six 11:40
half days, does that really cut it, or should a modern public health service be thinking with cleverly or with greater sophistication about what it wants from its cadre of medical managers?

A. I suppose the strategy side, actively involved in that. Service delivery, actively involved in supporting that. Professional leadership, clinical effectiveness, etcetera; I was involved in the governance section of that part so I think that part would have been covered. 11:10
Medical education, I've already said, was outside of my remit apart from teaching my own trainees. Leading the team and the modernisation, you know parts of that did take a huge amount of time. The Monday evening meetings I considered a huge amount of time on that 11:10
section.

MR. WOLFE KC: This is the Monday meetings with urology?

A. With urology. So there are aspects of it in certain specialties, certain areas, were done very well. There 11:10
were aspects probably in other specialties where they actually were able to manage themselves very well.

MR. WOLFE KC: Obviously the mainstay of your working week was your clinical responsibilities?

A. Yes. 11:10

1 Q. Is there a sense that the responsibilities of the Associate Medical Director's role were something of an add-on that you did when you could, but it was extremely difficult to prioritise them?

A. It was difficult prioritising everything, to be honest. 11:11
I did it -- at least I thought I did it well. The days I had the meetings, for example with Heather Trouton Wednesday afternoon, that was because it suited my clinical activities. The Friday morning meetings

recently, November 2021, you did not include the full three PA requirement, which was in your job plan, to this role. Is another way of saying that is that you weren't able to fully commit all of the hours available to you on the job plan to that role? 14:43

A. No. My job plan was full, and rather than take something out to replace it with AMD time, I left the AMD time as less than the 12 hours. I didn't have my job plan being for hours that I didn't exist in the day, if you like. 14:44

45 Q. You did the hours required for the AMD role, but they just didn't feature?

A. I did what I was able to and what I needed to, often working in my own time, and indeed I often displaced some of my own clinical work into my own time in order to enable me to deliver activity as AMD. 14:44

46 Q. Is it fair to say that as you performed what appears to have been an important managerial role, given the issues that this Inquiry has to consider, at an important time for Urology, that you were always in danger of making compromises of that role because of your Clinical commitments and responsibilities? 14:44

A. I think that's fair to say, and I've reflected in my statement that there would have been meetings that I was not able to get to because they clashed with my clinical work, which continued. 14:45

47 Q. At one point, it was October 2018, you indicated to the then Director of Acute, Ms. Gishkori, that you were minded to resign your position as Associate Medical

meetings that you were regularly unable to attend because of your Clinical commitments?

A. I have mentioned the Patient Safety meetings in my statement and I have commented that there have been occasions and there are occasions where there is 14:52
a clash where the Patient Safety meeting in Belfast Trust is at a different session to the Patient Safety meeting in Craigavon or in Southern Trust, and therefore I could be conducting Belfast activity at the time of the Southern Trust Patient Safety meeting and 14:53
therefore not able to attend. There is also reality that the activity that I do in Belfast is primarily cancer activity, and a decision had been made to continue particularly cancer operating if it clashed with Patient Safety meetings. For instance, the Friday 14:53
morning when I am doing cancer surgery I still have an operating list to attend and carry out.

53 Q. Your inability to attend those meetings, I suppose, gives rise to the question: how suitable a role was this for a busy Clinician? 14:53

A. I think that's a very good question and I think others have reflected on having that same clash of Clinical activity with their Clinical Management activity.

54 Q. You are holding a thought there. Do you want to finish? 14:54

A. I think there is always -- in order to provide leadership as a Clinician, the Clinician needs to, in some way have, if you like, that respect of the team. You need a Clinician who is a Clinician in a Clinical

Management position. Ultimately, on this subject, I think we would need to be stronger in our expectation of Clinicians that actually in order to take this on you need to withdraw from being the full-time Clinician that you are. 14:54

55 Q. That's perhaps a helpful general reflection. Could I -- could I ask the question maybe more provocatively. In terms of what we are facing up to within this Inquiry, which is an exploration in part of whether the Governance System within the Trust was fit for purpose. 14:55 Was your absence from the wheel of some of these key meetings, and perhaps other Governance-related activity, does that offer some kind of explanation, at least in part, for any ineffectiveness of the Governance Framework? 14:55

A. Specifically in relation to Mr. O'Brien?

56 Q. Yes.

A. I don't believe so, because I was alive to and aware of the issues in relation to the concerns. My absence, say, from the Acute Clinical Governance didn't mean 14:56 that I was not aware of the SAI reports and their recommendations. I was very aware, because, as you know, I was on that SAI team.

57 Q. Yes. Of course an inability to make formal meetings is perhaps just one part of the job. How did you go about 14:56 conducting the role even informally? Did you make a point of ensuring your antenna was alive in receiving necessary information from colleagues?

A. In terms of informally, I have mentioned that I would

reviewed on a monthly basis. I do not retain copies of the risk register but anticipate that the Trust would retain same.

42. There was a computerised system operated trust wide; the Patient Administrative System. The Trust was not yet entirely paperless and there were also paper charts.

43. PAS did not change while I was there. The PAS (mentioned above) was a hospital system. There was also a NIECR system which GPs could also access.

44. The performance objectives were more or less dictated by the SLA with the HSCB. Doctors' job planning reflected the service need and was done with the medical line manager. Areas for training and development and SPA allocation were also identified in the job plan. The system was set up so that I was the eventual signatory. I had nothing to do with drafting the content of these.
Appraisals were facilitated by the line manager.) The Trust would retain copies of these.

45. This was not my responsibility but I believe the process worked effectively. There were time pressures with the nature of the workload experienced by the Consultants and it could have been more efficient. Doctors would occasionally have to give up SPA in order to attend clinics/ theatre etc depending on workload.

46. At first instance the concern would have been brought to the line manager (unless their line manager was involved.) If it was in relation to patient care which was dangerous they had to act immediately. An IR1 (DATIX) would have been raised. The line manager would make the decision to attempt to resolve at the lowest possible level. The IR1 in the meantime would go to the Head of Service, Martina Corrigan. I do not recall any specific incidents relating to urology. IR1 are recorded on an online system which is called Datix.

47. I, For the most part yes I did. Mark Haynes was the AMD for urology. We were supposed to meet monthly however he rarely attended scheduled meetings and he rarely attempted to make any informal contact with me. He was unable to provide time. Ronan Carroll was the AD and he regularly kept me informed, he attended the monthly meeting and directly reported to me. He was reliable and honest.
The Head of Service, Martina Corrigan did not report directly to me but she would have on occasion came with Ronan to meetings as required and I found her supportive.
Any dealings with Consultants would have been on an ad hoc basis and this would have been rare. Mr O'Brien did not come to my office at any time.

48. Please see paras 2,3 and 5. Question 48 (i) – (ix) should include the following individuals as follows.

the really good surgeon, his outcomes can initially look poor. You need to do a lot more drilling down on the fitness, etcetera, of the patient and the complications, etcetera, to decide is his data as poor as it initially seems. That's just one of the disadvantages of it. As an overall tool, it can be very useful for helping to pick things up like that, yes. 11:35

MR. WOLFE KC: You were in this role eight years. Did you feel, at least on a personal level, generally supported by each of the medical directors you worked under? 11:35

A. Reasonably well, yes. Paddy Loughran was new. He had been Daisy Hill based but I worked probably with him. Richard Wright only arrived in the summer before I -- he arrived in the summer and I ceased to be AMD in the following April, so there was not a lot of time or interaction with him in that respect. Most of the time then would have been more John Simpson. I was moderately supported. 11:36

MR. WOLFE KC: That suggests a lot more could have been done to help you? 11:36

A. Well, shall we say, I suspected more of an interpersonal relationship. I thought I was alone but then I realised other AMDs had the same, felt there was an interpersonal relationship. I thought initially it was just me, but later on talking to them, they felt it was -- maybe it was the nature of how he did things, how he related to people, etcetera. 11:37

this role?

A. On or before 12 months.

277 Q. Can you recall the exact date you took over again, sorry?

A. I would say 29 April. 14:26

278 Q. Now, the Inquiry Panel has already heard evidence from your predecessor on the other side of the house, Mr. Mackle. The impression he gave us was quite a taxing job. Would you agree with that?

A. I would. 14:26

279 Q. You're obviously in the -- I'll say unique position of being AMD for two sections at the same time. Was it possible for any one person to do this job?

A. Well, that depends on the support you have above and below. 14:26

280 Q. Perhaps, then, why don't we turn to what support you may have had. So you were in the medical management line. How did you find any support you were receiving from the Medical Director?

A. Not as much as would have been helpful. 14:27

281 Q. Well, what support was there from the Medical Director, first?

A. With regards to what?

282 Q. With regards to discharging your duties as Associate Medical Director? 14:27

A. Well, in the previous -- he was appointed, I would say, in July 2015. I think in that time up until April we had two one-to-ones.

283 Q. So that's two one-to-one meetings in, approximately,

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

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

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

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19. Issues around timely surgical reviews of referrals/daily consultant reviews/DNAR discussions.
20. M&M meeting dysfunctional.
21. JOB PLANS

That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

I'd be interested in your thoughts.

Charlie

Received from Charles McAllister on 09/06/22. Annotated by the Urology Services Inquiry.

1. There is no real functioning structure for dealing with governance."

If we just scroll down, I think a total of 22 perhaps, 21 different issues you had identified in a two-week period in surgery. Were you surprised being an experienced Associate Medical Director to find this amount of issues in your in-tray? 14:35

A. No. I'd say I was horrified.

317 Q. What horrified you in particular? Was it the scale of the problems? The amount, the extent, the length of them? What horrified you? 14:35

A. All of that. It was the breadth and the depth.

318 Q. You sign-off your e-mail with: 14:35

"That's what has appeared so far. Basically a very disturbing picture. Significant governance risks."

Did you consider that this was almost a mission critical type issue, this needed to be escalated? 14:35

A. Yes, absolutely.

319 Q. This email was sent to Mr. Carroll, who is the Assistant Director, relatively new in post. Mrs. Gishkori has probably been there at least from some time in 2015, and Dr. Wright again from 2015. Why did you take it upon yourself to email them this list of issues? What were you expecting? 14:36

A. Well there were several reasons in my mind. Number one, I wanted to ensure that the issues were clearly

files at home, I just wonder how shocked you were or were you surprised?

A. I mentioned Mr. Young, Mr. Young is also an absolutely outstanding surgeon. Mr. O'Brien is the slowest human being I have ever seen. Everything, everything is slow. Everything. So was I surprised when I heard? It added up. 16:30

CHAIR: Thank you. I'm just checking my notes here to make sure there's nothing else I want to ask you before I hand you over to my colleagues. Yes, I think you've answered the questions I had for you. Thank you very much. Dr. Swart? 16:31

588 Q. DR. SWART: I'm particularly struck by your letter about the 21 things you discovered in your first couple of weeks as AMD that you wrote to the Medical Director and others and the lack of response to that. When you said there's no ineffective governance, basically, what was it you were particularly thinking about? What was the thing that shocked you the most or you thought was the most important in that big long list? 16:31

A. What shocked me the most?

589 Q. Yes.

A. It would be hard to choose what shocked me the most. It was the lack of overall structures for ensuring practical and effective governance. 16:32

590 Q. For example, did you think there was any effective mechanism for assuring Patient Safety, quality of outcome, that kind of thing?

A. Sorry, Patient Safety?

73.5 No mechanism exists to monitor any individual clinician's decision making in outpatients. Issues only come to light when concern is raised by another clinician – be it a GP or a colleague. In Mr O'Brien's case, the ability of GPs or consultant colleagues to identify issues will have been impaired by the absence of letters. Additionally, the workload placed on the consultant urologists by virtue of the capacity:demand mismatch would have impacted on their ability to recognize issues. Single consultant practice also impacts, as for many outpatient conditions only one consultant may see a patient during a long disease natural history.

73.6 The absence of an induction process or handover for incoming AMDs was also a factor. For example, it was only after the identification of the untriaged referrals in 2017 that I was made aware that this had been an issue previously with Mr O'Brien. The resultant lack of continuity within the system resulted in, effectively, a clean slate each time there was a change in the medical management personnel at Clincial Director and Associate Medical Director level.

73.7 Being aware now of the clinical issues, in particular with regard to Mr O'Brien's prostate cancer management, it is in my opinion clear that conformance with external recommendations / guidance was a factor – be they MDM recommendations, NICE Guidelines or other external recommendations. I am told individual oncologists had raised concerns directly with Mr O'Brien regarding his use of low dose bicalutamide but Mr O'Brien did not change his practice. On reflection, other behaviours (such as his continued use of monopolar / glycine for transurethral surgery despite external recommendations) should have alerted others to the likelihood that he was not following other forms of external guidance. I am aware that similar behavior from Mr O'Brien regarding external recommendations was encountered following the 'Improving outcomes guidance' which recommended centralization of specific cancer related surgery within cancer networks. For Urology this covered Cystectomy for bladder cancer, radical prostatectomy for prostate cancer, penile cancer surgery and nephron sparing / IVC thrombectomy surgery for kidney cancer. After cystectomy surgery was centralized to Belfast, despite (I understand) having been told that no further

Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

no further questions, thank you.

CHAIR: Thank you Mr. Beech. I'm sorry we can't release you just yet. We have some questions for you ourselves, Dr. McAllister.

DR. McALLISTER WAS QUESTIONED BY THE INQUIRY AS FOLLOWS:

566 Q. CHAIR: One of the first things you say in your statement to us was you talked, and Mr. Beech drew this to your attention, about the tsunami of policies and protocols that were produced by the Department between 2005 and 2016. I just wondered what time, as a busy clinician, you would have had to read, assimilate those policies and protocols? 16:18

A. You wouldn't.

567 Q. You wouldn't, and would all those policies and protocols -- well, would any of them have training attached? I mean you don't recall the training you had in MHPS, but you do remember there was some now? 16:18

A. I think, and I said it in my statement, I think that for something as fundamental as MHPS and the Trust Guidelines, just to fire out guidelines and maybe to train one or two people misses the whole point.

It is important that every permanent medical employee is aware of the guidelines, aware of the process, and gets training in it so they understand what they are facing into if they are subject to either informal or

It is not to say it was discarded, it was part of the -- it was a part of the role but there was a significant amount of time spent on performance.

MR. WOLFE KC: Performance, in a layperson's term, is output, how many bodies can we get through the system? 10:55

A. Yes.

MR. WOLFE KC: I mean, I'm conscious we're talking in sort of high-level general terms, but are you reflecting the view that if performance is the focus, then there's at least the risk that some other 10:56 important things like quality of output is missed or given less emphasis?

A. I would think that quality was not overtly discarded, was not consciously discarded but it probably, as a result, wasn't always given as high -- I'm trying to 10:56 think how to balance it. It is not to say it was ignored. At the same time the big driver from the commissioners was towards service-based agreements and output, etcetera, and that was what we were trying to concentrate on to be sure that we could meet that. 10:56

MR. WOLFE KC: Was that across the board in surgery?

A. Yes.

MR. WOLFE KC: We'll go on in a short while to look at the meetings that you had to conduct with urology practitioners on a Monday evening, I think it was. The 10:57 debates that were had around that table, could they be reduced to debates about performance versus quality or was the driver -- to put it another way, was the driver for those meetings you wishing to take forward the

A. Yes.
66 Q. The two formal mechanisms, if we could call them that, that were available, you didn't have any awareness of?
A. That's correct.
67 Q. Was it your understanding then, as the Head of Service, that if there were issues with doctors, then those issues were dealt with by other doctors? 10:44
A. Yes.
68 Q. Was that an expectation that you had for those in senior management, the medics in senior management in Urology, that you would have assumed or hoped that they would deal with the issues arising from other medics? 10:45
A. I did, yes. Because I would have had a, again, good relationship with all of my CDs and AMDs and Clinical Lead. Any issues that I would have brought to them, I wouldn't feel that I was cope fit to deal with it. So, yes, I expected that. 10:45
69 Q. You referred in your witness statement the way you considered that things should be escalated or, in your experience, were, at WIT-39882, paragraph 7.1 where you've said: 10:45

"I can confirm that I had not previously implemented or applied the MHPS Framework or Trust guidelines in my role but my understanding, and what I confirm I did during my tenure, was that, if there was a concern with a member of clinical staff highlighted or brought to my attention, I raised with this with either the clinical lead of Urology, which was Michael Young, and/or the 10:45

have demanding day jobs, ensuring the flow of patients both electively and as emergencies, and the day to day running of their services. It would benefit those managers if they had more input and support in responding to complaints and queries, and had the time to identify trends and patterns in areas such as complaints/SAI/queries coming in from, e.g., MLAs and MPs, which could then be discussed with the Divisional teams. I think that the accountability should still lie with the Divisional team but it would assist greatly if there was someone who could gather information for complaints and meet with consultants, organise patient meetings, etc. and if this member of staff could be part of the Divisional team.

e. In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff they need to know who this is and what authority they have as their accountable manage. It is my observation that there wasn't a clear line of accountability/management whilst I was in post. So, whilst the consultants were directly accountable to their Responsible Officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a Clinical Lead (Mr Young), and whilst I believe it was understood that he should be managing the rest of the Urological consultants, Mr Young never had an actual job description outlining what this should entail and (from my recollection) only got 0.5 PA to be the Clinical Lead, so I don't believe that he ever felt that this was his role (although this would be a matter best addressed with him). I do feel that it was unfair in any event to have peers attempting to manage peers as these were their colleagues and it was hard to hold them to account when they were of the same grade. Equally, it was difficult for a non-urologist clinician to manage them as they were not familiar with the way the service worked, hence the reliance on the Head

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

133 Q. Another example:

"My role in clinical governance was as a doctor in the position of being a consultant. This involved mentoring junior staff and providing a continuous high standard of care for patients."

So that's paragraph 7.3 of your statement. Then paragraph 38.4:

"My specific governance role in the unit I regarded as maintaining the work schedule for the whole medical team and, as such, was operational. Assurance of governance was as a hospital consultant, but the responsibility of governance lay with management structure and the Medical Director's team."

So, again, you're placing yourself as having no additional responsibility for clinical governance as compared with your fellow consultants; is that fair? 14:16

A. I regarded my element of higher sort of governance and management to be at a low level in that sort of ranking of seniority that you've just raised. So I felt that I was, if I can maybe use the phrase, the captain of the team, potentially, but I was working alongside my peers and with them. I wasn't having a direct responsibility for them, and that's what I was trying to get across. So I'm working as a doctor, I'm working as a consultant, working alongside my colleagues.

databases associated with identifying concerns. These collective data systems of waiting lists, datix and SAI are a productive mechanism in highlighting specific areas of concerns for groups and in identifying individual areas of concern, as raised later in the Mr O'Brien section of this statement.

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

48.1 Generally, these systems collect a lot of data but only on the individual patient as opposed to overall trends. However, it is the methods that offer the overall collective assessment of the data which identifies trends and this is where the Datix system is meant to contribute. For instance, if there are repeated Datix reports on patients admitted with sepsis and this group of patients are identified to be overdue a surgical treatment, this produces a trend report. SAIs may also identify common themes. Albeit that the triage issue had already been identified, I believe that the Datix system would have highlighted the point by the booking system at an earlier stage and flagged to the governance team in charge of this system, which is an independent system to the Booking Office. The Datix system, I believe, did define the trend in the inappropriate dosage of the prostate cancer drug being prescribed. The SAI reports also suggested a trend and were the trigger for the subsequent Root Cause Analysis. These two data collecting methods have been introduced in recent years and are showing their efficacy.

48.2 I am unaware of any other significant upgrade in these hospital systems.

49. As Clinical Lead, what was your role and responsibilities with regard to the Consultants and other clinicians working in Urology Services, including in matters of clinical governance?

49.1 As noted previously the Lead Clinician role is service-based and did not have a direct responsibility for other consultants other than a working relationship alongside them as colleagues on a daily basis and offering support and advice.

164 Q. We also heard evidence from people in various roles, I'm thinking particularly of the clinical lead role now where there was a statement there was no job description, no formal development for clinician leads; there seemed to be a rather confused understanding of the role of clinical governance of any such role. Does that surprise you? 15:34

A. No, I think I would be very sympathetic to lead clinician. In a medical management structure, medical leadership structure, that's quite thin on the ground; well meant when it was first developed. But when that's thin on the ground, I think there's an awful lot expected of the lead clinician when they are trying to help. My view of the lead clinicians was that they're trying to help us. I wouldn't have been expecting too much of them. I also thought that we should be going easy on the lead clinicians because I wanted them to apply for clinical director posts; I wanted them as a sort of introduction to medical leadership. 15:35 15:35

Again with the whole pressure of activity and so forth, I had great sympathy for anyone who was a lead clinician.

165 Q. How should that be fixed because they need time, they need development, they need guidance? It's a hard job. 15:35

A. I wonder should we have them really, because I think you are better off as a clinical director. When I was doing the psychiatry job MD, I had two clinical directors. They had sessions to work with me, they

safety lead; Mr. Glackin, cancer MDT lead; Mr. Tyson, standards and guidance and quality improvement lead - two separate roles. Mr. Young, rota clinical lead. Mr. Haynes is obviously Divisional Medical Director and holds the NICaN Chair. And is it Ms. McAuley or Mr. McAuley is the educational lead? So there are supports there, and as you explain and we'll see in a moment, particularly around the medical professional governance, the roles occupied by your Deputy Medical Directors help to streamline and bring focus to some of the key professional governance issues that arise. But you seem to acknowledge that there is an element of looseness or weakness around the medical leadership responsibilities that fall to Clinical Directors and Divisional Medical Directors because they simply don't have the time to do it in as much depth as safety might require? 10:53 10:53 10:54

A. I think there are always particular challenges on their time. I mean one of the things that we did do was to double the amount of time that the Clinical Directors had. So when I came into the Trust, the Clinical Directors had four hours a week, and in some of those cases that was to manage scores of doctors and to try to be cognisant of, you know, patient safety issues and any areas for development. So we increased the number of those and doubled the time that was given to each post. But the - I mean that - the Clinical Director role is also really challenged in relation to doing this. 10:54 10:54

19.1. In my view, practically every department in the HSC is under-resourced and understaffed. I do not know if the stresses felt in Urology were greater than other specialties. I do not know if there were staffing problems and, if there were, whether they impacted upon management and governance. I have had minimal, managerial involvement in the Urology unit for nearly 12 years, so I am not very familiar with these issues.

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

20.1. I had clinical engagement with the Urology service from 1993 to 2017. I provided a basic, and mainly diagnostic, urological service in DHH and I referred a lot of patients to the CAH Urology department. I observed the department develop from a single-handed consultant (Aidan O'Brien) to a team of six or seven consultants (I'm not sure exactly) and a complement of junior staff and trainees. During the period from 2008-2010 when I was CD, I think that the number of consultants increased to three. I know that there was Aidan O'Brien and Michael Young, but I am not completely sure if there was a third or of the name. There may have been other staff who were appointed resigned or replaced during my tenure, but I have no accurate recollection of precisely when staff came or left. The Trust could provide information on dates of appointments and resignations. Again I think Michael Young (Lead Urologist), Martina Corrigan (HOS) or Heather Trouton (AD) would be able to provide information on staffing.

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

21.1. Governance is part of the role of any clinical manager. Clinical managers include the Clinical Director, Associate Medical Director, Medical Director and Director of Acute Services. The CD's role was mainly dealing with high, and often immediate priority, issues such as staffing, recruitment, rotas, timetables etc. Governance was part of it, but I would not have had in-depth knowledge, or total overview, of all the governance arrangements and issues in all of the six departments for which I had responsibility. These six

Received from Robin Brown on 16/06/22. Annotated by the Urology Services Inquiry.

departments were General Surgery in DHH, General Surgery CAH, Urology CAH, ENT CAH, Orthopaedics CAH and Ophthalmology CAH. Please see paragraph 1.2. I was CD for SEC (Including Urology) for 2 years and 9 months from 01.01.2008 to 31.08.2010 and CD for DHH (not including Urology) from 01.09.1010 to 31/03/2016. During that time my contribution to governance in Urology was mostly reactive, in that I addressed issues brought to my attention. Please see paragraphs 24.2 and 24.3.

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

22.1 The Urology Service was supported by the Head of Service, Martina Corrigan who reported to Simon Gibson (AD) followed by Heather Trouton (AD).There were many other non-clinical staff who worked with Martina, Simon and Heather but I am not able to accurately recall names and titles. I think that Martina Corrigan, Simon Gibson and Heather Trouton would be able to supply this information. There were, for example, operational support leads, cancer trackers and booking centre staff. I was based in DHH and virtually all the support services and non-clinical managers were located in CAH.

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

23.1 To my knowledge each consultant had their own secretary. The Head of Service would have worked with the team and was not allocated to a particular consultant. I do not know how administrative workload was monitored. I would suggest that Martina Corrigan (HOS) or Heather Trouton (AD) could answer this question.

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

Received from Robin Brown on 16/06/22. Annotated by the Urology Services Inquiry.

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

86. The Lead Consultant would have had team responsibility and another consultant chaired the MDM. As explained above, the main elements of clinical governance (that is: quality assurance, education, clinic audit, research and development) were all organized by the specialty team of consultants under the direction of the lead consultant (Mr Young). I was fully aware that the events and activities were taking place and participated in joint audit meetings that encompassed all surgical specialties. I was therefore able to witness case presentations and morbidity and mortality reports by the urology team at such meetings. My oversight role was to be informed or appraised of patient safety matters that arose out of audit of activity or patient safety meetings. The significant governance concern arose out of an audit of activity of Mr. O'Brien. It was clear there was the potential for a clinical effectiveness issue and on this I had frequent updates.

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

87. Quality of service roles and supervision in urology would have been shared between the Lead Consultant, Head of Service, Assistant Director, AMD, and Director of Acute Services.

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

Trust, did not appraise for about 2 years after us. John Simpson, our MD at the time, was very keen on appraisal and developed systems more quickly than others.

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

45.1 I think this was mainly the AMDs and the medical director, with senior admin staff, who were involved. The process usually would start with an SAI or complaint, and be investigated. If action was needed it was at a higher level than me. Some would have been anonymised and discussed at audit meetings for learning.

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

46.1 Generally I felt well supported by my AMD, Eamon Mackle, as he was always available if I needed to discuss anything. I had no involvement in urology.

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

The Chief Executive(s);
the Medical Director(s);

management to the possibility of a potential incident that may need further investigation, were submitted from SEC. These were screened by a panel of clinicians and members of the managerial team. This role was extended to include the urology cases highlighted by Professor Sethia after his look back review. This review was over an eighteen month period from January 2019 until June 2020. I also attended the monthly acute governance meeting chaired by the Director of Acute services, Mrs Melanie McClements. At these meetings I presented any completed SAI reports from my division.

7.3 Job planning – I conducted the job planning review for the ENT and Urology teams. This entailed a look back at the previous year's job plan, agreeing any new changes in the working week for the Consultant, adding in any new additional responsibilities, making sure adequate time for in the job plan for administration, supporting professional activities and education. Some job plans were straightforward and could be agreed in one meeting or discussion. Others were more complex and required additional time and meetings to get agreement.

7.4 I was not involved in the specialty patient safety meetings for urology but I attended the combined surgical and anaesthetics patient safety meeting which occurred once every three months

Q8.**It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Medical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.**

8.1 As a clinician my role was different from the Head of Service, Assistant Director and Director of Acute services. They are all nonclinical managers and deal with the operational side Urology services. My role was to work within the clinical managerial team. This team is made up of the Lead Clinician, the Clinical Director, the Associate Medical Director/ Divisional Medical Director. We all report to the Medical Director.

8.2 During my tenure. I was able to assist with service delivery through my role in the Regional Prioritisation oversight group (RPOG). The COVID pandemic presented a major challenge to the already stretched urology service. Through this work I was able to help secure additional operating capacity for urology in the Independent sector and in the regional elective care centre.

8.3 My main role involved assisting with the job planning process, presenting any Urology SAI reports at the monthly governance meeting, dealing with all levels of staff educational and study leave, approving claims for waiting list and locum work. I also did some Consultant Appraisal work.

8.4 My role frequently overlapped with the work of the Associate Medical Director, Mr Haynes. As Mr Haynes was a Consultant Urologist issues relating to Urology tended to be brought directly to his attention rather than mine. He was often better placed than I was to answer questions on Urology specific issues.

Received from Edward (Ted) McNaboe, on 14/06/22. Annotated by the Urology Services Inquiry.

I just want to stop there, just for a moment. What you are setting there is the scene. You being off site, I think it's fair to say a summary of that evidence is that you felt that that, in some way, limited your access to information that may have informed your role?

A. Yes. I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated. So, I mean, the team in Daisy Hill, I was seeing them on a regular basis, I was meeting them in theatre, and so we were chatting about things in the tea room, but there were no tea-room conversations that I could have with the clinicians or the people in Craigavon. When I did meet with management, it was in an official meeting.

27 Q. When you talk about your interactions as Clinical Director in Daisy Hill, and you've mentioned it in your statement, as well as those informal ways of gathering information that you have just described, as Clinical Director, did you have any procedures, formal weekly meetings, any processes set up by which there was a structure to some sort of oversight around governance for you as Clinical Director?

A. Are we talking about pre-2008 or after 2008?

28 Q. Well, when you took up your post as Clinical Director in 2008?

A. In 2008. We had a weekly meeting, a team meeting, as all teams do, we had a team meeting every Friday

157. I believe the urology service was very busy and stretched. But that did not explain the behavior of one Consultant which, in retrospect and at the time, was outside acceptable practice. The issue was the difference of opinion of a single Consultant versus their peers, the Trust, and its Acute Services Directorate. I believe a change in AMD and CD did not help to sustain an approach with good briefing of previous initiatives. The Directorate should have employed external review and had an experienced team to provide ongoing oversight. It should not have been the appointed task of a newly appointed Clinical Director (me) in the first few weeks of that appointment to undertake a completely informal attempt to resolve a previous longstanding issue that previous senior managers had failed to resolve. In my view it was a mistake to be appointed to be lead Case Investigator under MHPS, therefore creating a conflict of roles, viz, Case Investigator vs. Clinical Director for the same consultant (Mr. O'Brien). However, this mistake was later rectified and a new Case Investigator appointed.

158. There was too much separation between clinical and operational management and there should have been regular team meetings of all concerned. These should have been minuted.

159. However, despite multiple meetings across MHPS, job planning, and frequent review within a set framework, the consultant reverted to the same pattern of behaviour. It is hard to know how to change this when considerable effort was made to avoid this; maybe an acceptance that the consultant could not cope with the workload but this also required the individual to accept changes in their practice commensurate with safe working.

Received from Colin Weir on 21/06/2022. Annotated by the Urology Services Inquiry.

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

160. In retrospect, a much closer working relationship between senior operational and clinical managers was needed as well as better oversight by having all individuals involved, not just by frequent email. Governance at the unit level would need better support with a governance lead appointed or someone with governance responsibility.

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

161. The engagement was frequent, and clearly identified. I believe a large number of individuals were involved in attempts to resolve the issues in the unit (as detailed in various answers above). I believe reasonable attempts were made to resolve the issues in the best interests of patients both informally and formally and with close monitoring.

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

96. I have explained (e.g., at Questions 5 to 8 above) that my role in clinical governance was limited other than a main issue with Mr. O'Brien.

97. Within approximately 2 weeks of commencing appointment as Clinical Director I was made aware of an ongoing unresolved governance issue with one of the consultants in the unit (Mr. O'Brien). This was during regular weekly meetings with the Associate Medical Director (Dr McAllister). The issues raised were of Mr. O'Brien's failure to triage patients in a timely manner, that there was a review backlog of oupatients, and that because there was a backlog of dictated letters there were no outcomes recorded in many cases. Also, there were a significant number of NHS/HSC notes belonging to the Trust that Mr. O'Brien kept at home. At this stage I was not informed of precise numbers, how long this had been occurring, what previous action plans and meetings had occurred to address this, or any other significant briefing. I consider it a failure of good governance to ask a newly appointed Clinical Director with no previous experience to resolve, informally, a longstanding and complex problem with only a weekly meeting with my line manager.

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

98. I was not aware of concerns in governance meeting minutes and I have no record of such documents or any other type of governance documentation. I had no involvement or written communication regarding the Risk Register.

essential. No amount of sitting through courses or role play could fully prepare an investigator for a complex case without backup support or shadowing.

59. As Clinical Director (Clinical Manager), more frequent meetings with the team, both clinical and operational hierarchy, would have been better. There was too much of a 'top down' approach, with one level dictating or asking the next level down to undertake a task or implement a policy. A team approach would, I believe, have helped monitor situations better and a horizontal management structure would have communicated and acted better in my view.

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

60. The MHPS process was, in retrospect, the best and only way to progress the concerns raised. Understanding that repeated attempts made on previous occasions to resolve the situation had failed, meant that a formal MHPS process was appropriate. A formal process should, in my view, have started sooner. The period of time for a suggested informal approach was, in retrospect, pointless.

61. The investigations were robust, fair and well documented and the plans were clear, written and without any ambiguity. The use of an oversight group, written terms of reference, and documentation were all within the Trust's documented structures for the implementation of MHPS.

62. There was ample opportunity for Mr. O'Brien to understand, reflect and challenge decisions and, during my tenure as Case Investigator, I listened and reflected on his desire to return to work and advised the Oversight Group

inappropriate cases on at the weekend or at night, the anaesthetists will figure this out, the other surgeons will figure this out, and complaints will be made. If it is systemic and it is one person that will very quickly come up. You know, people will make that very clear. A misappropriation and utilisation of an urgent theatre, you can't carry on doing that. I can't see any reason to have investigated further if none of those issues had arisen before. 12:40

208 Q. Based on your opinion, having looked at this as well as your knowledge of Mr. O'Brien and how the theatres operate at these times, it is your opinion that this didn't meet the threshold requiring any further investigation? 12:41

A. I thought it was a cluster, a statistical cluster up the system. 12:41

209 Q. You didn't feel this needed escalation up the system?

A. It was already escalated to the Assistant Director, and I investigated it. I don't know what else we would have done at the time. 12:41

210 Q. If I take you to TRU-258912: Is it fair to say to after July 17th you're not aware with any other issues with the action plan until October '18, is that fair?

A. With the action plan, no.

211 Q. No, and if we look here at this email on the screen, this is October 2018, so by this stage the MHPS process is concluded. There has been a Case Manager's determination which has a number of actions to be taken forward. I believe at this time Mrs. Corrigan is off 12:41

from The Trust. There appears to have been some type of issue with the monitoring and this comes across your desk, and you email Dr. Kahn, and Mr. Gibson, Mr. Carroll, Ms. Clayton and Mr. Haynes. You say:

12:42

"Ahmed, Simon, please for your urgent consideration/action. See email correspondence below. Please see attached Excel spreadsheet. Mr. O'Brien has accumulated a large backlog of dictated letters and a large number of charts in his office. I am his 12:42
Clinical Director and I HAVE NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings. Can you instruct me on how you would like me to proceed. We can certainly meet with Ronan to discuss 12:43
recorded outcomes from the meeting."

Are you expressing some degree of frustration here that you haven't been made aware of the outcome of that MHPS process? 12:43

A. Yes. Yes.

212 Q. When do you consider you should have been made aware of that outcome?

A. As the process evolved, any determinations, we should have been made aware of those as they happened. 12:43

213 Q. Do you consider that without that knowledge of the precise outcomes, did that hamstring your ability to engage with Mr. O'Brien, or to try and tackle issues as they came?

A. No, I think if this suddenly appeared then, obviously, there was an immediate concern and it's clear that I would have been very happy as a Clinical Director to engage with Mr. O'Brien and say, look, you're in breach of this action plan. I didn't see a difficulty with that. In fact, I'm saying, what do you want me to do? I'll be happy to do it.

214 Q. From the line which reads:

"I have not seen the review and results and recommendations into his practice." 12:44

You're clearly aware by the time you send this email that that process has, in fact, concluded?

A. Well, I'm assuming. I actually don't know that it is concluded, to be honest with you. I didn't have a final report or that. So I was assuming that it had concluded. 12:44

215 Q. I'll ask you the same question I asked earlier, and I'm expecting the same response: Could you not have chased the Case Manager to find out what was happening with the investigation? 12:44

A. Could the Case Manager not have chased me? And that's -- yeah.

216 Q. Now, there's perhaps one final substantive MHPS-type issue I want to talk to you about today, and that's at TRU-251964. This is an email from -- if you go right down to the bottom, please. This is an email from Mr. Carroll to Siobhán Hynds to which you are copied 12:44

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI (DHH)

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark
Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

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

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to dictated
Mr Jakob					18	25.09.18	30
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29
Mr Haynes	0	0	19	26.09.18	0		55
Mr O'Brien	17	0	91	15.06.18	0		
Mr O'Donoghue					15	26.09.18	12

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

What support were you imaging Dr. McAllister was going to give you in bringing this plan into action?

A. I was very clear right from the outset of this that this was not to be entirely me to manage this, to implement it. I felt it was important that somebody else more senior in the management team or medical management team was involved in this. And I was very clear about that right from the start, that I didn't feel comfortable. That I was one person being asked to deal with a very long-standing, complex problem which seemed to me to be getting worse over time, not better. It was very easy -- I could see scapegoating issues being -- you know, if this didn't happen then, you know -- I felt that I needed some cover from the more senior medical management team to help me do this. I was happy to do it. I was happy to have those meetings. But that's -- I felt it was important for me to have back-up for that. 11:39 11:40 11:40

128 Q. If we just go up, please, further up the email chain. Thank you very much. This is Dr. McAllister's reply on 21 September. He says that: 11:40

"Apart from the fact you spelt his name wrong, it is absolutely excellent and I agree completely. It would be important to do this in a positive constructive supportive role that Mr. O'Brien be aware of this." 11:40

Did you feel at that time as if you were getting the support of Dr. McAllister to go ahead?

A. Yes, that was very supportive, excellent. Very happy with that.

129 Q. If we keep moving up, please. Mr. Carroll himself has some additions and some comments to make on 22 September. 11:41

So from 21st September, whenever Dr. McAllister comes back and endorses your plan, and you say you were happy with his engagement, what steps did you take to put this plan into action? 11:41

A. There was no -- I don't think there was any steps. I think that was as far as we got in producing the plan. So there was nothing -- we didn't progress it beyond that into an actual face-to-face meeting -- or at least that didn't happen in that timeframe. 11:42

130 Q. I'm sure the Inquiry will be interested to know why. What reason stopped this plan which had been endorsed, which you created, which you say you are wanting by, in from the Associate Medical Director, you said you had that? 11:42

A. As far as I can recall it was just a matter of getting everybody available to meet up to start this process.

131 Q. I'm not trying to be difficult, Mr. Weir. You say you needed to get everyone to meet up to start the process?

A. To have myself, Dr. McAllister, and Mr. O'Brien, I suppose, in the first instance available. 11:42

132 Q. You had Dr. McAllister's blessing and, according to your own plan, which we can see here copied by Mr. Carroll into his email, you were to have the

initial face-to-face meetings with Mr. O'Brien. It was on you to have these meetings with Mr. O'Brien. There doesn't really seem to be a suggestion that the Assistant Medical Director was --

A. No, the first meeting would involve you, me and Mr. O'Brien. That was written to Dr. McAllister. 11:43

133 Q. You're quite right. But having got this plan green lit, are you simply telling the Inquiry it was because you couldn't get yourself and Dr. McAllister in a room with Mr. O'Brien? 11:43

A. Yes. Just having a time to get things, yes.

134 Q. We know, as you said at the start, that Dr. McAllister subsequently left his role as Associate Medical Director. That wasn't until 13th October 2016. Was there really no time that you and Dr. McAllister could meet with Mr. O'Brien before that departure of Dr. McAllister? 11:43

A. You know, there may have been. I just don't recall what circumstances were driving against that. I mean, you know, all of us at the time had busy clinical practices and other commitments as well. I think it was just a matter of finding the time available to get the thing started, and kick started. 11:44

135 Q. This is a matter which has raised concern at pretty high levels in the Trust. You have the Acute Director Mrs. Gishkori interested in this. You have the Medical Director, Dr. Wright looking to take some type of action. Did you not appreciate there was some level of urgency to try and work this out with Mr. O'Brien 11:44

before it spiralled into something much more serious?

A. Yes there was. Yes, I guess there was a sense of urgency or needing something to get started on this. But that, I suppose, regretfully, we didn't get to the point of that first meeting within that, you know, within a few weeks of that email being sent. 11:45

136 Q. I know that you, yourself, had a period of absence from the Trust in November. Mr. O'Brien was off on sick leave from 15th November 2016. Even after McAllister has stepped down from Associate Medical Director, was there no opportunity for you to meet with Mr. O'Brien to action this plan? 11:45

A. Once there was no Associate Medical Director, that was, to me that was -- because all of this was coming from Mrs. Gishkori and Dr. McAllister. It was their view that this was the way to deal with this. It was their asking that something be done in this less formal way. So, once Dr. McAllister was no longer available, I felt that everything was up in the air again. 11:45

137 Q. On the end, perhaps if we could just refer back -- 11:46

A. Sorry, can I also say as well, once you lose Dr. McAllister, then that changes all our roles in an instant, and what we're required to do as well as our clinical work and take on, you know, our managerial roles, that has changed. 11:46

138 Q. If we could get AOB-01053 back up on the screen, please?

You've been very candid today about your reluctance to tackle this without support. Yes, you're correct that Dr. McAllister was off from 13th October, but if we go down to Dr. Wright's email of 15th September, albeit somewhat reluctantly, he does, in effect, endorse the approach which McAllister has been trumpeting, i.e. that you were to sit down with Aidan O'Brien, work out a plan and you had 3 months to do so. You had the Medical Director on your side too. Was that not a sufficient support for you to go in and meet with Mr. O'Brien? 11:47 11:47

A. Yes, but the whole thing was predicated on the chain being -- to Medical Director, Mrs. Gishkori, then Dr. McAllister. Their meetings. Oversight Committee meetings of which I was completely unaware. A desire to run this in this way. The requirement for me to work with somebody else to do this. And suddenly that was taken away from me. You know, so it left me in a difficult position and exposed, again, as to how I was the going to run this investigation single handedly. I know you feel that there may have been a sense of urgency, but we were dealing with something that was going back a long way that was deep and complex and recurrent and persistent, as far as I could see. I felt, again, that I was being left to be the one person to deal with this and sort this out. I don't think I was happy with that. 11:47 11:48 11:48

139 Q. We'll see from Dr. Wright's email on the screen, 15th September, that he says:

"I would need to see what plans are in place to deal with the issues and understand how progress would be tracked."

You produced a plan the next day. The evidence we have got is that the Medical Director's office never received a copy of your plan. Did you take steps to share it with the Medical Director? 11:49

A. No, but I wasn't asked to. I did share it with my Associate Medical Director and the Director of Acute Services. I heard that the Medical Director had a degree of involvement or in terms of an Oversight Committee, so to me it seemed natural to go up the chain of command that I had already been working with. 11:49

140 Q. I suppose, before we leave this period of time which the Inquiry is interested in, I would like to raise an issue concerning Patient 93, who I believe you refer to in your Section 21 response at WIT-19904, paragraph 13, please. I'm aware we're jumping back. 11:49

11:50

"On 31st August Mr. Haynes noted a patient of Mr. O'Brien's was not triaged.
After the square brackets it picks up: "The patient was seen by me for leg pain, possibly due to a circulation issue, but metastatic disease was noted in keeping with metastatic prostatic carcinoma. The triage delay was 3.5 months and apparently this would not have changed the outcome". 11:50

any further instances?

A. No.

222 Q. I am very aware that time is perhaps not on our side here, but I wonder if we could have a very quick discussion about Job Plan? 12:50

A. Can I just, sorry, can I please?

223 Q. Sorry, you have something to add there?

A. At that time I was undergoing some really pretty brutal treatment. It was right in the middle of that period of time. So that's another reason that might explain things. 12:50

224 Q. Thank you, Mr. Weir, and sorry if I cut across you in my desire to move forward.

I do want to do this issue justice, but I just want to have a quick discussion about job planning, if that's okay. If we look at WIT-19936, which is your Section 21 response, paragraph 102. You accept that you were responsible for job planning the Consultant Neurologists? 12:50

A. Yes.

225 Q. With regards to the other consultants, Haynes, Young, Glackin, Donoghue, did you ever have any significant issues with their job plans?

A. No. 12:51

226 Q. Here at paragraph 102 you say

"In one case (Mr. O'Brien) this was complex and repetitive and required many hours work by me to

achieve an agreed job plan."

What made Mr. O'Brien's job planning complex, whereas the others appear to be relatively straightforward?

A. So Mr. O'Brien wanted to -- so one of the issues with job planning is that when you have a week of emergencies, urologist of the week, or surgeon of the week, whatever, all your other elective work stops and you totally are committed to that week of emergency and urgent care. 12:51

So there's a cycle; like typically a 1-week-in-6 cycle, that has to be job planned. But then the complexities became around Mr. O'Brien wanting to work in the Southwest Acute Hospital in Enniskillen where he did a clinic on alternative weeks. So then we went from a 6-week cycle to a 12-week cycle. Added to that, he was Chair of a Cancer MDT and felt he needed additional time to prepare for that in the style that he wanted to. 12:52

So I was having to factor out a complicated pattern of alternating weeks, between rosters of the week and outlying clinics, and then other activities. Some of those were calculated to be done week-to-week, but some of them, what we do, is we analyse them to say you deliver so many activities of over a year and that has to appear in the job plan. It's an exceedingly complicated process when you get into sort of details 12:52

and nitty-gritty like this.

227 Q. Would you look at WIT-19948, please, paragraph 113, sorry 116. In the preceding paragraphs in fairness to you, you outline various attempts to meet with Mr. O'Brien, October '16, the process drifts into August '17 and then it is into April '18, but the key point here I suppose is: 12:53

"By the commencement of my sick leave in mid-October 2018 through to December 2018, the job plan was not finalised, resolved, or signed-off in this Zircadian system." 12:53

So you are not able to get an agreed job plan?

A. No. 12:54

228 Q. At any stage during that two-year period did you put a flag up to someone on the system, the Assistant Director, the Medical Director, to say: Despite my efforts, I can't get this agreed? Did you ever raise and say, I need help to sort this out? 12:54

A. No, I did discuss it with Martina, Ms. Corrigan was fully aware, and I did discuss it with Martina. She knows how difficult it was, even to get the meetings and engagement to work through this process, and I honestly gave as much time, and it was a considerable amount of time to try and get this resolved and I thought I could. I got better and more experienced in using this zircadian system. It's complicated. Thankfully they've just replaced it this month with 12:54

a new system. You needed to have the engagement, but I felt I could do it and I felt at that point I was an experienced job planner. In any case, any job plan has to be signed-off by two other people. So once I sign it off, the consultant signs it off, it goes to the Assistant Director, it goes to the Assistant Medical Director. So there's a lot of input into it once you get to an agreed job plan position. 12:55

But, yes, you're right, I mean maybe somebody else could have done it or done it better than me. But I don't know who because I know that everybody struggles with the system. 12:55

229 Q. I suppose with Mr. O'Brien's case, it's not just a difficult job planning exercise, but there's this MHPS investigation where a lot of the issues appear to be administratively based? 12:55

A. Yeah.

230 Q. And at various times during your tenure as Clinical Director, there are statements that a key part of this process is a job planning exercise. So I'll give you an example of the case conference on 26 January 2017, which you were in attendance. The actions record: 12:56

"It was noted that Mr. O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties. There was considerations about whether there was a process for him highlighting an unstainable workload, it was agreed an urgent review 12:56

of Mr. O'Brien's job plan was required."

And the action to that is to you. Similarly, the Return to Work Plan in the second paragraph says:

12:56

"An urgent Job Plan Review will be undertaken to consider any workload pressures to ensure appropriate supports can be in place."

Finally, I am sorry for just reading these out to you, so this is the determination you don't actually see: 12:56

"The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and enhanced appraisal programme." 12:57

Now, I accept that after February you were a step removed from that MHPS process, but were you coming under pressure from above, from, say, the Case Manager, from those involved in the MHPS investigation to make sure this process was completed and completed promptly? 12:57

A. No. But myself and Martina, we did know there was still no proper sign-off job, it was my role to ensure that everybody had an up-to-date job plan every year. We were supposed to have an updated job plan every year. So it was very easy for me to see there's a red flag on the system saying there's still not a completed job 12:57

plan. So the system will flag that up, in a sense.

231 Q. In the context you just described, do you accept that agreeing a new job plan would have potentially assisted Mr. O'Brien in working through some of these issues, it could have provided him with support he may or may not have needed? 12:58

A. I met and discussed this many times, including on one occasion unsolicited 'phone calls on a Sunday afternoon when I wasn't working from Mr. O'Brien regarding, I think, job plans. It was complex and the complexity was trying to squeeze everything in to his job plan. There were certain things he wanted to do and there was things that I wanted him to do to get the balance right. And even agreeing quite reasonable numbers of patients to be seen at clinics, quite manageable numbers, so that it would help with his administration. So it was all -- it was kind of job planning but management of the person via job planning at the same time. So it was actually quite a useful tool and a powerful way of doing that. 12:58 12:59 12:59

So, you know, I was aware that maybe Mr. O'Brien didn't see as many patients in the clinic as other people, or me, for example, but that's fine, we just work at different speeds and work in different ways. So I was factoring all those things in and trying to be an honest broker in that sense. But I was trying to complete the process through engagement, which I just -- it was difficult to get the full engagement 12:59

we needed to get this over the line.

232 Q. One final issue from me at this stage is WIT-19906, please. We're looking at paragraph 17. There was an email exchange with Mr. O'Brien between 5th and 18th October to try and meet him to try and undertake a job plan review. So we're back in 2016. 13:00

You had no hesitation meeting with Mr. O'Brien about a job plan in October 2016, but you obviously had hesitation about meeting him with those other issues. If you could meet him to discuss a job plan, why could you not meet him to discuss your action plan you were proposing? 13:00

A. As I said, the action plan was kind of -- I felt exposed, vulnerable, that I was the only person doing this, that I needed back-up. I needed other people involved in that process and I didn't feel that had yet happened or -- you know, to me, it was a much longer term problem that we were trying to resolve. Whereas, not having done it before at that stage, to me it looked like, I've done loads of job planning before, it was pretty straightforward for most people. 13:00 13:01

233 Q. Thank you, Mr. Weir.

MR. BEECH **BL**: Madam Chair, I've taken us quite close to 1 o'clock. I have no further questions. 13:01

CHAIR: I think we have a few questions, if you don't mind staying on, Mr. Weir.

A. Of course.

A. To undertake the role to?
250 Q. Sitting down with Aidan O'Brien to say what's going on here and how is this going for you during this whole procedure. It's a long time, and it's not all in your remit, I'm just asking your opinion. 13:15
A. It could have been me, it could have been the Lead Consultant, it could have been the Associate Medical Director, it could be the Director of Acute Services and that's the problem. It just moves in all these different directions, and whose actually doing this. 13:15
Then when it becomes so complicated and multi-layered does everybody else think, you know, who is ultimately responsible for doing this and to make those lines a little bit more explicit and clear, particularly when there's a complex investigation ongoing at the same 13:15
time. I think that's -- yeah, that's it.
DR. SWART: Thank you.
CHAIR: Mr. Hanbury?
MR. HANBURY: You have answered a lot of my questions already. I have a couple of left. 13:15
Charts at home in the office.
A. Yes.
251 Q. Did Mr. O'Brien ever explain why he needed so many chart at home?
A. Not to me. 13:16
252 Q. And what the problem was, if there was a problem?
A. No. When the time it came to me doing my investigation, 24 January 2017, the bulk of those had been returned. I did think part of the problem was

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

30.5 My line manager is the Clinical Director for Urology, who in turn is responsible to the Medical Director.

30.6 Clinical Director with responsibility for Urology: Robin Brown Mid 2011 – January 2014, Sam Hall January 2014 – March 2016, Colin Weir June 2016 – December 2018, Ted McNaboe December 2018 – December 2021 – Currently Vacant

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

31. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

31.1 In my opinion the senior managers did not work well with Urology. Engagement with the department by the Clinical Directors, Medical Directors, Assistant Directors for Surgery and Directors for Acute Services was very limited and infrequent in my experience. I do not know how much job planned time they had allocated to management activity.

31.2 Mr Young tried his best to lead the Urology team. However, despite his best efforts Mr O'Brien, Mr Haynes and Mr O'Donoghue frequently failed to attend departmental meetings or arrived late. All too often I sat across the table from Mr Young wondering why my colleagues had not shown up. Due to the number of fronts on which the service was failing to deliver (growing waiting lists for appointments and surgery), it was difficult to achieve a consensus as to how to move forward without engagement from our colleagues.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director – Urology Improvement (Temporary post – 2 years initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Urology Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

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

Specific Divisional Responsibilities

- Provide medical leadership and direction regarding strategic development of Urology Services within the Southern Trust.

- In conjunction with the AD Surgery and Elective Care lead on the Urology review lookback and coordinate clinical resources as appropriate.

- In conjunction with the AD Surgery and Elective Care provide clinical leadership on the development of business cases to involve independent sector support for lookback reviews as required.

- Be the Trust key clinical contact for liaising with external bodies such as the Royal College of Surgeons and BAUS to gain independent expert advice on urology lookback and quality improvement proposals.

- Review and provide input into the modification of the department to improve and expand Urology services and have an active involvement in the implementation of quality improvement initiatives. This includes specifically:

  - Chairing the urology quality improvement group designated with responsibility for ensuring effective, high quality care is provided.

  - Co-Chairing the Urology SAI task and finish group responsible for ensuring compliance with SAI recommendations made in the 2016 and 2021 urology SAI reviews regarding urology and cancer services.

- Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

- Ensure Southern Trust policies and procedures in relation to Urology services are reviewed and updated regularly, and develop short term and long range plans for the department to maintain standards, implement improvements, define and measure progress to meet Southern Trust objectives.

- Provide oversight to senior management to ensure compliance with established practices, to implement new policies and to ensure employees are aware of changes and current standards

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
    (a) delivery of safe, high quality and effective person-centred care
    (b) secures activity and performance
    (c) maintains ongoing financial viability
    (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.

- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation
To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of DivMD allocation.

Job Planning
- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff
- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

    - Smoke Free policy
    - IT Security Policy and Code of Conduct

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

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

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

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

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

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director – Urology Improvement

DIRECTORATE Acute

Notes to applicants:

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

ESSENTIAL CRITERIA *– these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form*

whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

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

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise

themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

It appears we're not able to bring these recommendations up. We have a spreadsheet which shows the progress being made using a RAG status approach, TRU-320313. A number of the recommendations are already in play and some will be implemented in the course of this year. Could you help us, Mr. Haynes, in terms of what's emerged from the Getting It Right First Time analysis, do the kinds of recommendations coming through that present challenges to the Trust or are they broadly to be welcomed by you and your colleagues working within Urology Services? 16:21 16:21

A. Broadly welcomed. The clinicians, through the PIG Group, were all in support of the Northern Ireland -- the GIRFT assessment across Northern Ireland. Many of us, and recent actions are in green for some of them, or well underway, because prior to the inspection GIRFT have issued over the last number of years a number of reports into individual aspects of urological care, which we'd already set about delivering care alongside. There was a GIRFT report in delivering care for stone patients which we'd already set about delivering care according to. Indeed, one of the audits on the previous document was against the standards or the recommends within that document. 16:22 16:22

There's one for bladder outflow obstruction. Similarly, we'd already taken aspects of that and instigated them into part of our service. And our kidney cancer one. So in many respects --

161 Q. Are you saying it is almost giving the --
A. It is supporting the direction of travel we wanted to go.
162 Q. -- what you are seeking to do.
A. Yes. 16:23
163 Q. Sorry. We can work through some of these. Perhaps if we scroll up, I think the recommendations are summarised onto this sheet from the report, and we can see some of them. We don't have the time, perhaps, to work through the fine details, but could you attempt to 16:23 characterise for us what the ambition of these recommendations indicates and where will this bring Urology Service, both locally in your Trust and regionally, if the Department and the commissioner can resource them effectively? 16:24
A. I think effectively the aim of the GIRFT document is about what things outside of more resource can be done to deliver care more effectively. It encourages, as you see within that recommendation that is in front, the use of advance nurse practitioners and physicians' 16:24 associates to deliver care which would have previously been delivered by doctors. It encourages the developments of high-volume, low complexity surgical centres. It encourages network working for a service to support and maintain the service; in the case of 16:24 kidney cancer services in the recommendations in here. It encourages the development of specialist centres, so you make, if you like, the nonspecialist centres attractive to recruitment. It aims to address all the

things outside of more resource being put in that can improve the service for patients but also for the staff delivering that care.

164 Q. We can see, you touched earlier, you touched several times on the role of the region, which is manifest through the operation of PIG, as I described it earlier, the Programme Improvement Group. I think you reflected positively about that group. Can you help us better understand what that group is, how often it meets, what its objectives are, and how does it work? 16:25

A. So I haven't reread but there is a terms of reference that was updated, I think, earlier this year and sent round. Essentially the group is made up of representatives from SPPG, who chair it, there's Department of Health representatives. From each Trust that provide urological services, there are clinical representatives and there's managerial representatives. It is a proactive group at all levels, with good relationships, and relationships that do challenge how things are being done. So we have had discussions that you could describe as lively or challenging, but there is no issue with having them discussions and them challenging conversations. But everyone in that group is working towards a positive outcome in the delivery of care, and the GIRFT report has provided a framework going forwards for many of the work streams that will come out from that PIG Group. 16:25 16:26 16:26 16:27

165 Q. I think it is fair to say that the GIRFT Report wasn't long off the press when it was discussed at the PIG

meeting in November. We can touch on that briefly, TRU-320308. We can see that the attendees at that meeting, including yourself and your colleague Mr. Tyson, Mr. Glackin. As you say, chaired by David McCormack of the SPPG and attended by various stakeholders, including representatives of the Belfast and Southeastern Trust, Southwestern Trust and the Department of Health. If we scroll down, you can see that GIRFT has just been reported and it's on the agenda, summarised by Mr. McCormack. Over the page, he sets out, I suppose, the action that's going to be required, which involves some prioritisation of the recommendations, Task and Finish Groups to be set up within each urology unit but a clear understanding that there would need to be a regional focus. The Inquiry can see from documents supplied that this was the subject of further discussion at the January meeting and no doubt so on. 16:28 16:28 16:28

In terms of the benefits that the implementation of GIRFT might bring, where do you see those benefits being most obvious for the Southern Trust? 16:29

A. As I say, the drive supported the direction of travel we wanted to go. The establishment of a specialist service in Southern Trust provides, I think, some confidence that we will be able to recruit and attract people into a specialist post. The support for the network for kidney cancer service is really important because there has been a change in how kidney cancer is 16:29

managed surgically, which has inevitably meant the number of kidney removals, whole kidney removals, in each Trust has dropped dramatically. The number of open operations for big cancers has dropped dramatically. Left in isolation, there was always a risk of the kidney cancer surgeons finding themselves unable to continue in the districts where support, outreach and cross-network working will hopefully prevent that from happening. 16:30

It's very clinically led so the goals are driven by GIRFT, which is body coming with -- which is clinicians lead the final -- do the inspections and write the report. It is supported by us as clinicians. That clinical leadership in delivery of this will hopefully mean that we will have a service that is not only safe for patients but what we want and what we see as the best way of delivering care. 16:31

I think the name of the group, Getting It Right First Time, gives it away. If someone is referred with suspected kidney cancer, they should see a kidney cancer surgeon, and that's this goal but split across all of the services. 16:31

166 Q. I suppose to bring it back to a slightly more sober place, perhaps, the GIRFT report - I'm not going to try to bring it up on the screen because I think I've lost that battle already - the GIRFT report reflects in its executive summary that Northern Ireland has witnessed 16:31

a 10-year, a decade long, deterioration in its Urology Services. It reflects that in terms of specialist urologists, we in Northern Ireland are underrepresented by reference to our population compared to other regions in this island. There are structures that are not set up to deliver care at its most efficient. 16:32

The implementation of the GIRFT recommendations is not going to correct the waiting lists as they stand; isn't that right? 16:33

A. As we said, the GIRFT recommendations are part of the picture of the not adding in resource. You touched on there that the number of consultant neurologists per head of population in Northern Ireland is lower than elsewhere across the NHS, and that's been the case since I've been here. There's a challenge across the NHS as a whole, and I think it is touched on in the GIRFT report, that there are vacant posts everywhere. 16:33

We have a unique challenge in Northern Ireland. We have a border with another country where the consultant pay package is different to here and so there is a disincentive to people moving across the island. There's a disincentive to people who don't already have a base in Northern Ireland moving from England, Scotland or Wales. They have to uproot and move across the sea and they get paid less, and they are moving into a service which is challenged for waiting times, it is much more stressful when you have 16:33

constant -- you know, every consultation is difficult when the patient asks the inevitable, "and how long will I wait". So there are many disincentives that we can't fix, but we can fix trying to deliver care in the best way. 16:34

167 Q. Thank you for your evidence. I have no further questions for you. I leave you to the Panel.

CHAIR: Thank you, Mr. Wolfe. I know Mr. Hanbury will have some technical questions for you.

16:34

THE WITNESS WAS EXAMINED BY THE INQUIRY PANEL AS FOLLOWS:

168 Q. MR. HANBURY: Mr. Wolfe has asked most of my questions but I just have a few outstanding ones. I'll try to keep it narrowed down. 16:35

Looking at preop assessment, we have talked about Patient 90 and 91, there was still an opportunity to avoid the problems that ensued with the WHO checklist. I wonder what your thoughts are on perhaps why those cases slipped through the net there, and are you confident that that's working better now? 16:35

A. Yeah. I mean, of course there are opportunities for them cases to not proceed. Both patients were seen on the morning by an anaesthetist and a surgeon. There was an opportunity at the time of the checklist to discuss whether the patient was optimally assessed. 16:35

Getting it Right First Time

Urology across Northern Ireland

October 2023



This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable the urgent restoration of elective urological services and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

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Received from SHSCT 01/12/2023 Annotated by the Urology Services Inquiry.

Foreword

Getting It Right First Time (GIRFT) is a national Programme in England developed by the GIRFT National Team under the Chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. It helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The High Volume Low Complexity (HVLC) programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways (HVLC programme - Getting It Right First Time - GIRFT).

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the Chairmanship of Professor Tim Briggs, was approached by the Northern Ireland Department of Health Elective and Cancer Services team to conduct a review of Urology across Northern Ireland using the GIRFT methodology and HVLC principles.

This report describes the findings and recommendations from the review, as well as laying out the objectives and the approach followed by the RNOH GIRFT team.



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Received from SHSCT 01/12/2023 Annotated by the Urology Services Inquiry.

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1. Executive Summary

This report is based on the data and observations from RNOH/GIRFT's face to face visits to all the Trusts in Northern Ireland to review their urology services. **Figure 1** shows the schedule of the visits. **Annex A** provides a full list of hospitals included in this review.

Figure 1: Schedule of visits

Trust	Visit Date
South Eastern Trust	Tuesday 16th May and Wednesday 17th May 2023
Belfast Trust	Wednesday 17th May 2023
Northern Trust	Thursday 18th May 2023
Southern Trust	Thursday 18th May 2023
Western Trust	Friday 19th May 2023

We have made a series of recommendations in this report which aim to tackle waiting lists, improve structures and ways of working and improve the quality of care. Consideration is given to other cross-cutting areas to improve performance, awareness and the governance of urology services across Northern Ireland.

It is now essential that the recommendations made in this report are immediately taken forward to improve care for patients and to put in place a structure and ways of working across Northern Ireland to deliver them. This will involve the Trusts working together and a blurring of their historical boundaries. Furthermore, it is essential that the changes introduced to increase elective surgery are resilient during the winter months; and must deliver elective care for 48 weeks per annum. We can no longer accept "shut down" of elective care during winter; it is not in the best interest of patients and will not reduce waiting lists.

We have made a total of **40 national recommendations** in this report. These include recommendations for the Department of Health to take forward nationally **(Section 2.1)** and recommendations where the Department of Health should encourage the implementation of over-arching recommendations to all Trusts, as many improvements apply to all providers **(Section 2.2)**.

Through a combination of Trust meetings and a review of the data provided, we observed variation in practice within Trusts, between Trusts and also when compared to NHS England urology metrics; some of the variation is unwarranted. Where we have observed this, we have challenged the Urology Teams and provide appropriate recommendations. Separate recommendations for each of the Trusts are detailed in **Annex B-F.**

We have provided a number of useful links to GIRFT Urology pathways and good practice guidance in **Annex G** along with a glossary of terms and abbreviations in **Annex H.**

The review team met with senior clinicians, managers and members of the trust executives at each of the five trusts providing services across Northern Ireland. There was an overwhelming sense amongst the people that we spoke with that provision of urological services across the Province had deteriorated over the past decade and that long-term planning was hampered by the absence of a functioning administration at Stormont and the current political vacuum.

The direct consequence of this is that budgetary planning is difficult, with in-year budgeting becoming the norm. Nevertheless, the RNOH/GIRFT team were very impressed with the

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strides that colleagues had made in discussions about how service should evolve in the specialty of Urology.

Given the population in Northern Ireland of 1.86 million, it is neither possible nor desirable that all elements of the specialty can be delivered to a high standard in each hospital. Rationalisation and delivery of high-quality services are essential to ensure that clinicians with the requisite experience and skills are available to manage routine and complex care. While this principle has been accepted in urological oncology (provision of surgery for prostate, bladder, kidney and penile malignancies) and surgical andrology, there is a general acceptance across the British Isles that surgery of bladder outflow obstruction, complex stone disease, female and functional / neuro-urology should also move in this direction. It is to the immense credit of the Urologists in Northern Ireland that planning for this scenario is well advanced. Implementation should be the next step to ensure a vibrant and sustainable service for Northern Ireland's population.

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2. Recommendations

2.1 General Recommendations for Northern Ireland Urology

No.	Department of Health Recommendations
1	DoH should establish a group of relevant stakeholders to lead on the development of an action plan to implement the GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The group will need to align with existing regional and local structures to ensure no duplication.
2	The DoH should continue to encourage and support Trusts to strengthen clinical coding processes, including the routine sharing of data with clinical teams.
3	The DoH should ensure that good governance arrangements are in place to enable patients to have timely access to investigations and ensure that all clinicians seeing outpatient referrals have access to Northern Ireland Electronic Care Record (NIERC), thereby avoiding duplication of imaging and unnecessary repeat appointments. This predominantly relates to the use of 'outsourcing'; there should be a focus on long term provision of outpatient care in order to obviate the need for this short-term support. This should be explored with the rollout of Encompass.
4	The DoH should support Trusts to strengthen clinical networking to further promote mutual aid, where differences in waiting access times and or differences in the volumes of backlogs exist.
5	The DoH needs to urgently work with providers to address the under-provision of theatre capacity in regard to the provision of major urological cancer surgery, including cystectomy, radical prostatectomy and renal surgery. In the first instance, Belfast Trust should also work to ensure the full delivery of commissioned theatre list for the urology service within the Belfast Trust.
6	DoH should consider supporting a formal renal surgery network at sites outside of Belfast City Hospital (BCH) that currently offer this surgery; this could help to de-pressurise other major urological cancer pathways at the City site.
7	The Public Health Agency (PHA), in conjunction with BHSCT, should initiate a strategic review of the provision of robotic assisted surgery for Northern Ireland in Urology and other specialties, recognising the likely developments in robotic surgery in the next decade.
8	The DoH should promote and enable further examples of cross-site working between clinical teams for the delivery of both benign and cancer urological services.
9	The DoH should consider initiating a review into the funding mechanisms for trusts providing specialist care in both oncology and sub specialist urology practice, ensuring that trusts are not disadvantaged by undertaking specialist work.
10	The DoH should continue to ensure that Trusts are actively working to reduce the reliance on external outsourcing of clinical care; this can be achieved through implementation of the GIRFT recommendations and principles
11	The DoH should formalise the plans for the long-term provision of surgical andrology for Northern Ireland.

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12	The DoH should formalise plans for the long-term provision of female and functional urology for Northern Ireland in conjunction with recommendations made in the GIRFT Uro-gynaecology report.
13	The DoH, in association with the Northern Ireland Medical and Dental Training Authority (NIMDTA), should undertake a review to ensure the national selection in Urology is the right model for recruitment into the specialty.
14	The DoH, in association with NIMDTA, to review the distribution of Urology trainees across NI, ensuring equity and access to training opportunities.
15	DoH, in partnership with trusts, should ensure robust processes/pathways and audit particularly of sub-specialty services to ensure they meet minimum quality standards, e.g. prostate cancer diagnostic pathways/ RARP/Cystectomy/ penile cancer etc. Quality standards should be agreed by subspecialist urologists in each area but already available for many subspecialty areas.

2.2 General Recommendations for the NI Department of Health and all Trusts

Northern Ireland Urology General Recommendations	
Outpatient Care	
1	As a priority, The DoH should support and encourage each Trust to plan for and establish a Urology Investigation Unit, where such a facility does not already exist (GIRFT Urology Investigation Units Guidance), to maximise the efficiency of elective outpatient services.
2	The DoH should ensure that Trusts strengthen the Advice and Guidance services and all referrals should undergo robust clinical triage by a senior clinician (medical or nursing), with downgrading of inappropriate red flag referrals (GIRFT Urology Outpatient Guidance).
3	As a matter of urgency, The DoH must support and encourage Trust Urology Teams to redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, with pre investigation imaging, where indicated arranged at triage prior to attendance.
4	The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.
5	The DoH should promote greater adoption of virtual reviews as well as further nurse specialist input into outpatient pathways.
6	The DoH should ensure that Trusts are offering patient-initiated follow-up (PIFU) rather than routine clinical review to suitable patients. Trusts should ensure that there are robust mechanisms in place for such patients to gain timely access back into secondary care.
7	The DoH should ensure that outpatient pathways are standardised across all Trusts to ensure there is consistency nationally for patient undergoing outpatient investigation or treatment.
8	Trusts should rapidly implement a flexible cystoscopy and transurethral laser ablation (TULA) service for 'red patches' and recurrent superficial bladder cancer in the outpatient setting.
Inpatient Urology and HVLC	
9	Trusts should ensure that suitable procedures (flexible cystoscopy, flexible cystoscopy and Botox, transperineal biopsy procedures, urodynamics etc.) are **not** routinely

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	performed in Trust theatres. These should be performed in an outpatient procedure room by default, not inpatient theatres '**Right procedure, right place' approach**'.
10	The PIG should ensure that there is continuous improvement work on moving existing in-patient pathways to daycase pathways and moving daycase pathways to an outpatient setting, where appropriate.
11	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
12	Trusts to implement the GIRFT guidance on theatre productivity, with appropriate listing and maximising theatre efficiency with SPPG oversight.
13	Where not already done, The DoH should ensure that Trusts implement an action plan for increasing the percentage of elective operations undertaken as day surgery, using the BADS guidance (Day case surgery - Getting It Right First Time - GIRFT).
14	The DoH should continue to ensure that Trusts have access to and efficiently utilise 'cold' HVLC sites, thereby ensuring that protected elective capacity is maintained regardless of winter or acute care pressures.
15	The Department of Health should continue to encourage Trusts to collaborate ensuring that there is equitable access across Northern Ireland for patients in regard to more specialist services for example: bladder outflow obstruction surgery, Percutaneous nephrolithotomy (PCNL), Extra-corporeal shock wave lithotripsy (ESWL) and Sacral nerve stimulation (SNM).
Urgent and Emergency Care (UEC)	
16	As an immediate action, Urologists (in collaboration with general surgery and emergency department colleagues) should develop contemporary, clear protocols for patients with urological conditions requiring urgent and emergency care (UEC). This is of particular importance for the Northern HSC where re-configuration of the current service is advised.
17	The Department of Health should ensure that Trusts offering on-site UEC services in urology should urgently develop ambulatory assessment facilities, where they do not already exist.
18	The Department of Health should ensure that Trusts offering on-site acute urological care should support clinical teams in developing a fully staffed 24/7 middle grade rota – these can comprise of an extended workforce, including doctors, nurse practitioners and or physicians' associates.
19	Each Trust must ensure there is a clear protocol and service-level agreement in place with an IR provider for the provision of interventional radiology, including out-of-hours cover.
20	Trusts must ensure there are established pathways for the provision of urgent ureteroscopy, extra-corporeal shockwave lithotripsy (ESWL) and bladder outflow surgery after acute presentation.
Specialist Urological Provision	
21	Performance Implementation Group to develop an approach for the delivery of Bladder Outlet Obstruction surgery (BOO) predicated on the use of two HVLC sites in Lagan Valley and Omagh Hospitals with agreed regional pathways.
22	The DoH should ensure that percutaneous nephro-lithotomy (PCNL) surgery for Northern Ireland should be centralised at Craigavon Area Hospital with agreed regional pathways.
23	The DoH should ensure that provision of extra-corporeal shockwave lithotripsy (ESWL) for Northern Ireland should be centralised at Craigavon Area Hospital, providing a timely service for urgent referrals.
24	The DoH should continue to ensure a co-ordinated approach to waiting list validation for outpatient and admitted pathways, with regular reporting of the clinical backlogs.

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25	The DoH should continue to actively work to reduce the reliance on external outsourcing of clinical care through implementation of the GIRFT recommendations and principles

3. Project Objectives

The aim of this review was to:

- Identify areas of improvement to help the Department of Health to have a better understanding about how Urology services are being delivered across the country with the ultimate aim of improving patient outcomes.
- Ensure Urology services are being delivered in line with the Elective Care Framework and the Department of Health's strategic direction on the expansion of the elective care centres regional model.
- Identify recommendations to improve the patient pathways for Urology in all Trusts in Northern Ireland through production of a final report.

4. Our Methodology and Approach

We followed the GIRFT methodology, structured as follows:

- **Data gathering** and structuring shared ahead of the deep dive visits
- **RNOH communication** about the programme (including HVLC)
- **Deep dive engagements** for each Trust, with relevant stakeholders present
- **National level report** explaining findings and recommendations.

Prior to each visit we issued a questionnaire to each Trust which asked for information on the workforce; on call arrangements; recruitment and the provision of urology services.

We examined the data looking for unwarranted variation e.g. differences between hospitals in areas such as:

- **Overall Activity Metrics** (Urology elective inpatient spells, day case spells, Virtual outpatient Attendance, RTT Pathways)
- **Emergency Urological Care** (Urology emergency admissions, Emergency stone admissions, Urinary retention, Urinary tract infection /Urosepsis, Testicular torsion)
- **High Volume Low Complexity (HVLC) Procedures** (Transurethral resection of bladder tumour (TURBT) procedures, bladder outflow obstruction procedures, ureteroscopy and stent management procedures)
- **Oncology (Kidney and Ureter)** (radical nephrectomy for cancer procedures, nephrectomy for benign disease procedures, partial nephrectomy procedures)
- **Oncology Prostate** (Radical prostatectomy procedures)
- **Stone management** (PCNL procedures, extracorporeal shockwave lithotripsy (ESWL))
- **Female and Functional** (stress urinary incontinence, colposuspensions, autologous fascial sling procedures, paraurethral bulking agents for incontinence, cystoscopy and botox procedures sacral neuromodulation)
- **Andrology** (Peyronnies disease, Urethroplasty procedures).

The deep dive engagements took place from Tuesday 16th May to Friday 19th May and were led by Kieran O'Flynn and John McGrath. Each deep dive was an opportunity for the Trust to provide an overview of their Urology services and current issues; this was followed by a review of the GIRFT data and a detailed discussion. All the meetings were well attended by a mixture

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of colleagues in Urology roles (clinicians, theatre staff, senior managers and allied health professionals) and colleagues from the Department of Health, all of whom contributed to the excellent discussions. This allowed the review team to gain a good understanding of the issues facing each Trust and their hospitals and to suggest improvements.

5. Urology Services Overview

Urology services are provided at four of the five Trusts. There is limited urological provision in the Northern Health and Social Care Trust. Patients requiring urological care are referred, depending on their postcode, to either Belfast Trust or Western Health and Social Care Service based at Altnagelvin. Similar arrangements apply for patients needing urgent and emergency care.

Urology is a broad specialty encompassing diseases of the kidney, bladder, prostate and genitalia. Approximately 40% of referrals are to establish a potential diagnosis of cancer (most commonly prostate or bladder cancer). These referrals are 'red flagged' and, due to their number, pose particular challenges in the arrangements for early assessment and management. Other common reasons for referral are lower urinary tract symptoms in older men and recurrent Urinary tract infections (UTI's - predominantly in women). All Trusts provide routine urological care, but each has encountered different challenges in relation to the timeliness of the care provided and for most patients unfortunately experience significant delays in getting access to both a timely diagnosis and/or treatment. The underlying reasons are explored further in the report.

The provision of specialist urological care is disparate throughout the province and is detailed in **Figure 2**. Most urological oncology (with the exception of penile cancer) is provided at Belfast Trust, with nephrectomy also being performed at Altnagelvin Area Hospital, Craigavon Area Hospital and the Ulster Hospital.

As can be seen from **Figure 2**, many elements of subspecialist practice in Urology are delivered at more than one trust. This has largely developed for historical reasons or due to the interests of a particular surgeon. For many elements of subspecialty practice, the numbers of procedures performed are small and this mitigates against developing a genuine expertise. The ability to deliver such services has also been hampered by the Covid pandemic, when much specialist non-oncological surgery was deferred, leading to de-skilling of surgeons. It is now opportune to consider how these services should be delivered in the future, ensuring that patients get access to high quality care, irrespective of their postcode.

In urological practice, transurethral prostatectomy (TURP) was considered the sentinel operation for the specialty. While bladder outflow obstruction surgery is currently delivered at all trusts, development in this area of urological practice mean that there are a number of newer treatment modalities available, many of which can be delivered safely as daycase procedure. Given the numbers of procedures performed in Northern Ireland each year, it is neither practicable nor financially viable for all newer modalities to be delivered at all trusts. Consolidation of these services is recommended and further discussed in **Section 8** of this report.

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Figure 2: Provision of Specialist Services in NI

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Oncology					
Radical Nephrectomy	Y	N	Lap-nephrectomy only	Y	Y
Partial Nephrectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Nephro-ureterectomy	Y	N	N	Y	Y
Cystectomy	Y	N	Referred to Belfast City Hospital	Y	Referred to Belfast City Hospital
Radical prostatectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Penile Cancer	Referred to Altnagelvin Area Hospital	N	Referred to Altnagelvin Area Hospital	Referred to Altnagelvin Area Hospital	Y
Stone disease					
PCNL	Y	N	Y	Y	Y
ESWL	Y	N	N	Y	Y
Female and Functional					
Stress Incontinence	Y	N	N	Y	Y
Bladder reconstruction	Y	N	N	N	Y
SNM	Y	N	N	N	Y
Andrology					
Urethroplasty	N	N	Y	N	Y
Peyronnies surgery	N	N	N	N	Y
Surgery for male stress incontinence	N	N	N	N	N

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6. Workforce and Training

The Urology workforce for Northern Ireland is detailed in **Figure 3**. The ratio of urologists per head of the population is one of the lowest in Europe and lags behind that in England.

There are a number of factors that contribute towards Northern Ireland's difficulty in recruiting and retaining a workforce in the specialty. These include geography, national trainee selection, remuneration, onerous on-call rotas and limitations in the ability to develop sub-specialist practice in the specialty. Given the current working conditions with a significant on-call burden, currently limited subspecialty practice and the failure to develop specialist nursing, it is difficult to see how the hospitals in Northern Ireland can continue to attract high calibre consultant Urologists in the future.

Across the four home nations, it is estimated that there are approximately 120 unfilled consultant posts in the specialty. As only 50 National training number's (NTN's) exit training each year with a Certificate of Completion of Training (CCT) in Urology, there is an undersupply of trainees and consultant recruitment for many trusts is challenging. Units with fewer than 8 consultants have particular difficulty attracting new consultants, again largely because of onerous on-call arrangements and a limited subspecialty practice.

Northern Ireland and its constituent hospitals are approaching a tipping point with its over-reliance on a locum workforce and the anticipated retirement and relocation of consultants in the near future. The Department of Health will need to explore methods to incentivise recruitment into units where there have been repeated attempts to appoint substantive consultants but no suitable applicants found. On the mainland, there have been measures such as enhanced salary, improved re-location packages and negotiation on the starting salary point for new appointees. Other measures, such as networked on-call to reduce overall frequency, can enhance a consultant's working life and remove the current disincentives.

Whereas each trust would like to support the development of new consultant appointments in Urology, development of a functioning Urology Area Network model was effectively paused at the onset of the Covid pandemic; in the interim, much discussion has taken place and there is a renewed interest in inter-hospital working. Good progress has been made in developing plans for the provision of specialist services across Northern Ireland and these are discussed elsewhere in the report.

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Figure 3: Current medical workforce

Trust	Funded Consultant Urologists	Consultant Urologists WTE	Trainees WTE	Trust doctors WTE	Physician Associate	Comments
Belfast HSC	8.8	8	5 StR (Funded = 5.0wte; 4.4wte in post) and 1 CT Doctor (Funded = 1.0wte)	1 (Funded = 3.0wte; 2 in post inc. 1 agency)	0	2x Trust (Specialty Grade) Doctors recruited Sept 2023 to take up positions before December 2023. In addition, there are, 2x temporary Clinical Fellows and 1x temporary LAS Doctors in post.
Northern HSC	0	0	0	0	0	
South Eastern HSC	7	6(1 on mat leave)	1	3	2	1 consultant post vacancy 1 locum consultant currently covering maternity leave
Southern HSC	6	4.41	3 (4.5 funded)	0.87 (1.1 funded)	0.5 (0.5 funded)	Current advertisement for 3 urologists Includes 1 long term agency locum 1 works half time at Belfast City
Western HSC	9	7.6	3 (0 funded)			2 vacant posts consultant posts

Each unit remains understaffed with respect to Urology Clinical Nurse Specialist (CNS) support, detailed in **Figure 4**, and this has a major impact on the functioning of the unit. There is a paucity of CNS provision in diagnostics, with CNS provision of prostate biopsy, flexible cystoscopy, flexible cystoscopy and Botox limited to Craigavon Area Hospital.

Figure 4: Current Whole Time Equivalent (WTE) clinical nurse specialist (CNS) and physician associate (PA) provision in Urology in NI

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Band> 8c and above	-	-	-	-	-
Band 8b	-	-	-	-	-
Band 8a	1.00	-	1.00	2.42	-
Band 7	2.00	-	1.00	4	6.27
Band 6	3.00	-	2.00	0	3.52
Band 5	0	-	-	0	0
Physician Associate	-	-	2	0.5	-

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As shown in **Figure 5,** there is currently no provision of flexible cystoscopy and laser ablation for recurrent superficial bladder cancer across NI; this is frequently delivered by nurse specialists in England (see section on outpatient provision). Such arrangements are standard elsewhere in the UK, where these services are provided in a dedicated outpatient setting / Urology Investigation Unit (UIU).

Figure 5: Provision of clinical nurse specialist roles by Trust

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Flexible Cystoscopy	N	N	Y	Y	N
Flexi Cystoscopy and TULA	N	N	N	N	N
Flexible cystoscopy and botox	N	N	N	Y	N
Male lower urinary tract symptoms	Y		Y	Y	Y
Transperineal prostate biopsy	N	N	N	Y	N
Prostate cancer surveillance	Y	N	Y	Y	Y
Renal cancer surveillance	Y	N	Y	Y	Y
Stone clinic	Y	N	Y	Y	Y
Andrology	N	N	Y	N	Y
Continence	Y	N	N	N	Y

There needs to be rapid expansion in terms of numbers of specialist nurses but also a rapid upskilling of the workforce. The latter may be accelerated using an academy style model at one or more Trusts, where there could be a focused effort on training lists and mentors.

7. Outpatients and diagnostics

The facilities for outpatient assessment in Urology vary considerably across Northern Ireland. Each of the sites are highly constrained by the lack of space and suitable consultation and treatment rooms. The average waits by Health and Social Care Trust and the facilities available are shown in **Figures 6 and 7**. The consequence of this is that patients cannot be seen at the same time by members of the Urology team (doctors, nurses and Physician Associates); as a direct consequence, patients often have repeat appointments to see different staff members and outcomes are delayed. The constraints almost certainly contribute to the heavy reliance on ‘outsourcing’ for outpatient referrals and diagnostics.

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Figure 6: Average waits by Health and Social Care Trust Northern Ireland[1] Accessed 16/6/23

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Red flag*	2	N/A	2	5	1
Urgent**	14	N/A	17	30	7
Routine	68	N/A	87	155	16
Outsourcing arrangements	A percentage of routine appointments.	N/A	A percentage of red flag cystoscopies and TP biopsies.	A majority of red flag and urgent appointments.	A percentage of no-red flag patients and cystoscopies related to COVID backlog.

**Red Flag:* *These appointments are allocated to patients with suspected Cancer diagnosis and are the highest priority.*
***Urgent:* *These appointments are allocated to patients with urgent care needs other than Cancer.*

Trust Urology Teams must, as a matter of urgency, redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, avoiding the necessity for outsourcing and repeat attendances.

The most glaring example is at Altnagelvin Area Hospital, where some urology activity is delivered in the ground floor outpatients department, but patients have other elements of outpatient care delivered in rooms adjacent to the ward using rooms and facilities that are cramped and ill-suited for the assigned roles. This is compounded by the fact that neither the nursing offices nor the consultant offices are located close by. Co-location of facilities would enhance team working and greatly facilitate throughput. The lack of dedicated space means that it is not possible to provide a contemporary transperineal prostate cancer diagnostic service as the allocated room is required for flexible cystoscopy and haematuria / recurrent bladder tumour assessments. The direct result is long waiting time for prostate and bladder cancer diagnostics due to inadequate facilities and understaffing.

Craigavon Area Hospital does have a co-located investigation unit though it is currently shared with other services when not required by the Urology service. There is a compelling case to use this area exclusively for urology, given the volume of outpatient and diagnostic work that will need to be delivered. This will be particularly pertinent when outsourcing of outpatient referrals ceases and additional capacity will be needed, which may include a need to expand the current unit to provide additional consulting / procedure rooms.

Relatively low staffing levels in the urology departments of Northern Irelands Hospitals are undoubtedly a source of real pressure when considering the ability to meet the outpatient demand.

The number of clinical nurse specialists is particularly low, given Northern Ireland's size and population. The nurses work exceptionally hard, largely concentrating their work on oncology provision with little dedicated CNS provision for 'benign urology'. At Altnagelvin Area Hospital, the oncology nurses are part of the Oncology directorate and hence lack the flexibility to cover both oncology and functional urology to meet the demands of the service. As discussed in

[1] My Waiting Times NI - DOH/HSCNI Strategic Planning and Performance Group (SPPG) – formerly HSCB

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Section 6, there is an urgent need to extend the role of specialist nurses and practitioners to meet the demand of the outpatient workload. Expansion of the medical workforce alone is not a sustainable long-term solution.

There is a definite sense across all units that both the nursing and medical urology team feel under-supported in the provision of contemporary facilities for the delivery of outpatient care. The current models do not serve the specialty well, as most units nationally have or are in the process of transitioning to a Urology Investigation Unit (UIU) type model. A UIU means that flexible cystoscopy, laser ablation, urodynamics and local anaesthetic prostate biopsy can be provided in one location by the extended Urology team, comprising medics and CNS's with a special interest. By co-locating facilities into one place, there is greater scope for one-stop models of care, as well as improved interaction and flexibility within the clinical team. Throughout the country, Urology has largely morphed into an outpatient specialty where, with appropriate and modern practices, patients can be rapidly seen and assessed without recourse to day-case or inpatient attendance. If implemented effectively, a functioning UIU can have a dramatic effect on the number of patients requiring day-case procedures or overnight stays. It is estimated that only 1:12-14 patients seen in UIU will then require some form of admission. One of the highest priorities for redesign of urological care in Northern Ireland should be the delivery of UIUs at all the urology units, scoped to provide a level of future-proofing in regard to the expected growth in demand for urological services, as the population ages. The recommendations are in line with the Richards Report[2] on development of diagnostic facilities.

Figure 7: Availability of outpatient facilities by Trust

Trust	Site	Urology Investigation Unit	Comment
Belfast HSC	Royal Victoria	No	Emergency care only
	Belfast City Hospital	No	Space available on level 3 for development of investigation unit delivering flexi cystoscopy and TPB
Northern HSC	Antrim Area Hospital	No	Limited in-reach model by visiting Urologist. BHSCT provides two clinics a week in Mid Ulster Hospital. SNS follow-up is delivered (nurse led with support from Medtronic)
	Causeway Hospital	No	Outreach OP clinics and flexible cystoscopy (Altnagelvin team)
	Whiteabbey	No	Flexible cystoscopy (delivered by Belfast Trust)
South Eastern HSC	Ulster Hospital	No	Flexible cystoscopy and TPB done in inpatient facility
	Lagan Valley	No	Daycase facilities only at present

[2] NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

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	Downpatrick	No	Limited capacity to deliver flexi cystoscopy
Southern HSC	Craigavon Area Hospital	Yes	Flexible cystoscopy and TPB delivered but facilities shared with other services if rooms not being utilised by the urology team at present
	Daisy Hill Hospital	No	Outpatient activity commenced August 2023, Day case and 23 hours stay facilities only at present
Western HSC	Altnagelvin Area Hospital	No	Disparate facilities across the hospital site
	South West Acute Hospital	No	No outpatient activity
	Omagh Hospital	No	Flexible cystoscopy in daycase theatre

None of Northern Ireland's Urology units offer transurethral ablation of bladder lesions (TULA). Investment in a dedicated handheld laser at each of the sites would enable access to flexible cystoscopy and laser ablation of small bladder tumours, avoiding the necessity for repeat visits or a daycase procedure. Many units nationally have found this investment be worthwhile with significant cost savings. The development of a TULA service has the potential to significantly reduce the requirement for day case cystoscopy and biopsies and treatment of small bladder lesions. The capital outlay is small, and the learning curve is short, with very rapid release of theatre capacity at all sites. As services nationally transition from day case to outpatient delivery, it's important that mechanisms are in place to record this significant activity.

There remain significant pressures with the 'trial without catheter' (TWOC) service in outpatients. Improving this element of the service, with timely access would enable more patients to be put on day surgery pathways and avoid long lengths of stay. A properly resourced TWOC service with a Standard Operating Model (SOP) across the Trusts should be seen as a priority for the Urology teams.

The diagnostic pathway for patients suspected of having prostate cancer is not optimal. Patients referred with a high Prostate Specific Antigen (PSA) and suspected prostate cancer are generally first seen in outpatients and then referred for a prostate MRI scan. Most units in England have adopted a straight to test model, subject to satisfactorily completed pro-forma from the GP. This approach is endorsed by NHS England NHS England Prostate Cancer Timed Diagnostic Pathway. Due to litigation fears, some consultants in NI prefer to see patients in outpatients before ordering an MRI scan. The pathway is also delayed due to limited access to MRI, delays in reporting and frequently delays in accessing transperineal biopsy (LATP) in outpatients and delays in pathology reporting. Without improvements to diagnostic resources in Northern Ireland, it will not be possible to deliver these pathways at the pace that is required for rapid diagnosis. It is noted that the NICAN Urology CRG are currently undertaking a pathway project relating to this and reflecting the approach advocated in the NHS England pathway document. It is recommended that the rapid role of this pathway following the initial pilot is supported across all trusts.

Prostate biopsy services have generally morphed from transrectal to transperineal biopsy, with the majority of services now being delivered in outpatients. The appointment of a prostate

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cancer navigator and a nationally agreed pathway has the potential to shorten the pathway and enable an upfront MRI, prior to first appointment, for those patients who meet the criteria. The NICAN Urology Clinical reference group should take this forward.

8. Elective Care

Based on the returned data from each of the Health and Social Trusts, it is difficult to make a direct comparison between the provision of the sentinel procedures in NI compared with England where Model Hospital[3] statistics are collected for 170 different metrics in the specialty. Some general observations can, however, be made. Each clinical team expressed concerns that the data collected did not reflect actual case volumes and while the data provides some insight, it cannot always be relied upon for capacity planning.

There is certainly scope nationally for significant improvement with day-case rates across the 'sentinel' procedures referred to in the GIRFT data pack (exemplars being TURBT and bladder outlet surgery), which should help relieve the pressure on in-patient beds. Further improvement should now be possible if the right facilities are provided and the philosophy regarding 'daycase as default' is built into the booking rules for these procedures and the pathways are supported by a dedicated nursing team. The development of the Daycase Unit at Lagan Valley Hospital has shown that it is possible to deliver TURBT, bladder outflow obstruction and ureteroscopy safely as a day case and this initiative is warmly applauded and should be replicated elsewhere. An important principle has been the concept that it is a system resource that can be used by multiple units, working to common standards. Single Patient Tracking List (PTL) waiting lists will be vital to eliminate inequities in access times between Trusts. This will necessitate consistent approaches to the evaluation and listing of patients for the respective procedures.

When compared to Model Hospital, the daycase rate for TURBT is likely to be below the England average at 19%. The current English national benchmark performance is 44% with examples in exemplar units of 80%. Barriers in NI include the limited availability of daycase facilities, a culture of admitting the patients anticipating an overnight stay although not required, surgeon and patient preference and the limited opening hours of daycase facilities where they exist.

Intravesical Mitomycin instillation is a vital component of TURBT and should be done in theatre at the end of the procedure, followed by a trial without catheter in the recovery area ahead of discharge. Although this is done in some units (for example, WHCST) there were no data available on Mitomycin instillation in the individual units, it was acknowledged that there are difficulties in delivering this effectively across all of NI. Reasons cited include lack of personnel, lack of training and resistance from pharmacy and theatre staff as well as disruption of the day-case pathway.

Urology Units in NI are encouraged to use 'day case as default' for the majority (60-70% at least) of bladder tumour resections and evidence nationally suggests that the *routine* use of post-operative catheterisation is not necessary. There are significant pressures on the delivery of TURBT at the City Hospital, largely due to constraints on access to theatre slots. This issue could potentially be addressed by provision of daycase facilities at either the Mater Hospital or Lagan Valley Hospital. Trans-urethral laser ablation (TULA) for small recurrent bladder lesions, provided in an outpatient setting also has the potential to free up theatre space. All units should implement a TULA service as a matter of priority.

[3] NHS England - Model Hospital

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The current provision of surgery for bladder outflow obstruction (BOO), **shown in Figure 8**, is poor, both in terms of treatment options and unacceptably long waiting times. At the time of writing, over 300 patients from across Northern Ireland have been waiting for bladder outflow surgery for more than four years. Whereas most BOO surgery in NI is delivered as an in-patient procedure, daycase surgery for BOO is uncommon but ripe for development. Many units in England now offer daycase surgery for BOO, with the current benchmark for England being 26% and exemplar units achieving a daycase rate in excess of 80%.

Excluding the backlog caused by Covid, men awaiting bladder outlet surgery represents the largest patient cohort nationally on the urology waiting list. Approximately 750 men require BOO surgery on an annual basis in NI. This need is not currently being met with patients experiencing long delays. As a consequence, some patients have been referred to Dublin for their treatment. Men with larger prostates, who have developed urinary retention, do particularly badly as they are not suitable for some of the newer available modalities and cannot currently access Holmium Enucleation of the Prostate (HoLEP) which would be the current standard of care.

Figure 8: Available surgical options for the treatment of male bladder outflow obstruction, by hospital.

Trust	Site	Available options for surgical treatment of BOO	Comment
Belfast HSC	Royal Victoria	Nil	
	Belfast City	TURiS and Prostate artery embolisation (PAE)	
Northern HSC	Antrim Area	None	Mid Ulster Hospital Magheraflt-Urolift
	Causeway	TURiS	
South Eastern HSC	Ulster Hospital	TURiS	HOLEP cases have commenced with mentoring to be completed by September 2023
	Lagan Valley	TURiS, REZUM and Greenlight laser	Urolift in development. Rezum and greenlight at LVH is utilised by other trust surgeons (e.g. Southern)
	Downpatrick	None	
Southern HSC	Craigavon	TURiS, Greenlight	
	Daisy Hill	TURiS	
Western HSC	Altnagelvin	TURiS	
	Omagh	Daycase TURiS	

Bladder outlet obstruction (BOO) surgery is now recognised an area of sub-specialist expertise and there is an emerging consensus that patients should have access to all suitable options,

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including Trans Urethral Resection in Saline (TURiS), Greenlight laser, Urolift, REZUM and HoLEP. There should be a two-centre model for the majority of BOO surgery in Northern Ireland, predicated on the nominated, protected elective capacity sites in Lagan Valley Hospital and Omagh Hospital. Holmium laser enucleation of the prostate poses a particular challenge as it is ideal for men with larger prostates but is not currently available at any sites. The service is being developed with mentoring of 2 consultants at the Ulster Hospital. There are 2 Surgeons in Southern Trust are also trained to deliver HoLEP with plans currently in place to utilise the Daisy Hill 23 hour stay elective unit to deliver this

There should be regional pathways in place for patients requiring BOO surgery and ideally there would be nurse-led assessment of these men and nurse-led consent for each of the procedures that form part of a regional pathway. This was explored at each of the deep dive visits and there was broad agreement for nurse-led consent and development of single PTL waiting lists for each of the BOO procedures.

Given the significant pressures on theatre access at inpatient sites, it will be important for patients, nurse specialists and urologists to be aware that a day case option should always be explored first as this will result in more timely care. The GIRFT Academy guide provides an algorithm for patient suitability for each of the procedure types: GIRFT Urology Guidance - Bladder Outlet Obstruction.

The practice of ureteroscopy appears to have changed over the past few years with more hospitals delivering the procedures as day case. 78% of ureteroscopies performed in South Eastern Trust are currently being delivered as day cases in line with contemporary practice in England, undoubtedly aided by the daycentre at Lagan Valley, this is being delivered by surgeons from South Eastern, Belfast and Southern Trusts. Trusts should aim to deliver the same day case rates across NI for all patients undergoing ureteroscopy, recognising that with the move of suitable patients to HVLC centres those patients undergoing ureteroscopy in inpatient setting are inevitably complex and will have a longer LOS.

9. Urgent and Emergency Care (UEC)

The current provision of urgent and emergency care in shown in **Figure 9**. In common with other regions in England, Trusts in Northern Ireland have seen an increase in the number of patients admitted with urological conditions. The true demand for urological care is likely to be under-represented as most patients with a urological diagnosis are coded under General Surgery at the time of initial admission.

There is an overwhelming impression that the pathways for patients with urological diagnoses requiring urgent or emergency care do not function satisfactorily, and a post code lottery exists with regard to adequacy of emergency care provision. There needs to be an urgent addressing of the issues described below.

The underlying problems with UEC relate to poorly designed and functioning pathways, a fragmented middle-tier emergency care urology service and inadequate provision of acute beds for those patients requiring onward admission from Northern Health and Social Care Trust to either Altnagelvin or the Belfast Trust. At the heart of the issue are communication problems between the trusts and a lack of formal dialogue in agreeing these clear and standardised protocols.

Antrim Area Hospital and Causeway Area Hospital have no urological cover on-site and rely on inter-hospital transfer for patients requiring on-going urological care, based on postcode. Surgeons, ED clinicians and medical staff report significant problems referring patients to both Belfast City and Altnagelvin Hospital, with delays and at times a reluctance to transfer certain

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patients. There was a specific issue highlighted with deployment of non-specific advice from the on-call urology team ('admit locally' was the term entered in patient notes) and then difficulty getting consistent advice from the neighbouring urology unit the following day. Patients experience delays at Antrim Area Hospital and Causeway Area Hospital and spend an unreasonable length of time, either in the ED department or on a ward, without adequate consultant supervision. Criticism can be levelled both ways. 20-30% of admissions in the generality of surgery have a urological component. Working in a hospital with a functioning ED unit and no urology cover means that the staff will have to engage with urological problems and cannot abrogate responsibility for patients who require admission and stabilisation. There is an urgent need for co-designed urgent and emergency pathways for the common acute urological conditions that outline standards of care for patients and the responsibilities of the referring and the admitting units.

Figure 9: Provision of urgent and emergency care, by hospital.

Trust	Site	Emergency admissions	Inpatient Urology
Belfast HSC	Royal Victoria	Y	Y
	Belfast City	N	Y
Northern HSC	Antrim	Transfer	N
	Causeway	Transfer	N
South Eastern HSC	Ulster Hospital	Y	Y
	Lagan Valley	Transfer	N
	Downpatrick	Transfer	N
Southern HSC	Craigavon	Y	Y
	Daisy Hill	Transfer	Some 23hr stay
Western HSC	Altnagelvin	Y	Y
	SWAH	Transfer	N

It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Area Hospital directed to Altnagelvin.

Arrangements at the Royal Victoria for the reception of emergency urological admissions are inadequate. By default, patients are admitted through the ED department as a Urology Assessment Unit does not exist. From ED, patients are then admitted to ward 4 (an orthopaedic ward), which has little dedicated urological nursing and is perceived as having a

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lesser interest in the urological patients by comparison to its base specialty of orthopaedics. For a hospital of this size, there should be provision of an ambulatory assessment unit, either as a stand-alone clinical area or within a generic surgical assessment unit. Referrals from general practice or surrounding hospitals would then be sent directly to the assessment unit, allowing more rapid access to urological care and relieving the pressure of inappropriate routing through ED.

Due to service pressures, Urologists have difficulty accessing confidential enquiry into Peri-operative deaths (CEPOD) theatre lists for the acute management of haematuria or emergency ureteroscopy for stones. Under these circumstances, patients are more likely to get a ureteric stent (rather than primary ureteroscopy and laser lithotripsy) with inevitable delays in their long-term management. This contrasts with efficient pathways for emergency cholecystectomy in general surgery. Access for category one cases, such as acute testicular torsion, was reported to be good and there was no sense that these more urgent cases were delayed. The same was true of percutaneous drainage of the kidney in interventional radiology at BCH but this was not the case in other sites.

Whereas most patients with urinary retention do not require admission, patients do require a timely trial without catheter following ED attendance. In many Trusts, the arrangements appear to be haphazard: patients sometimes get a TWOC in the community or at the admitting hospital, but if that fails they are then re-catheterised and referred for consideration of onward surgical treatment. Patients then wait months or years for an appointment and definitive surgical treatment. It is well accepted that patients with indwelling catheters experience greater morbidity with recurrent Urinary tract infections (UTIs), haematuria and urosepsis. The inability to provide a timely service for these patients results in more emergency and unscheduled care. Given the elective backlogs, there is an urgent need to streamline the pathway for men who present with urinary retention and fail a subsequent TWOC. Such measures could include dedicated, rapid-access outpatient slots or a TWOC service based in the setting of a UIU (where there is clinical expertise on-site to support a same-day, shared-decision on the need for bladder outlet surgery).

The situation with regard to patients presenting with ureteric colic varies across the province. There appears to be no up to date pathway in the Northern area for the onward referral of patients needing emergency stone treatment. Clinicians at Antrim and Causeway were unclear as to the modalities of treatment that might be offered for a patient presenting with acute ureteric colic (either ESWL or acute ureteroscopy). Despite NICE guidance supporting its use, acute ESWL is rarely used across the province and provision of acute ureteroscopy is generally poor at all sites. There needs to be a clear pathway in place to ensure that patients can easily be referred from all sites for acute onward ESWL and this should be built into the plans for the fixed-site lithotripsy service at Craigavon Area Hospital. In terms of acute ureteroscopy, pathways should also be developed for either surgery at the time of initial admission (reliant on CEPOD access) or a ‘book and return’ model of care. The latter can also work well in protected elective care sites, such as Lagan Valley.

Access to interventional radiology by trust is detailed in Figure 10 and is essentially limited onsite to normal working hours in most Trusts, with the exception of the Royal Victoria Hospital. Given the current workforce issues in interventional radiology, access to these services will inevitably be constrained; a functioning SOP with service level agreements at each Trust is required to ensure timely access to the service, with a guaranteed repatriation once the immediate crisis is resolved.

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10. Specialist Care

10.1 Oncology

The current arrangements for major oncological surgery are shown in **Figure 10** and are derived from the pre-visit questionnaire. The estimated figures for the uro-oncological surgery requirement are shown in **Figure 11** below.

The majority of operative uro-oncology is provided for at Belfast City Hospital, but there are significant capacity challenges in delivering a timely service. At present, Belfast City Hospital has seven theatres, two of which are undergoing refurbishment on a rolling basis. It is estimated that this process will not be completed for the next 18-24 months. Although there is a DaVinci Robot in place, it is underused and even if it was operated at full capacity it is unlikely that an operative programme based on a single robot would be sufficient to meet NI needs. This is particularly true as the provision of radical cystectomy and radical nephrectomy has now moved towards robotically-assisted surgery as the approach of choice.

Figure 10: Provision of Oncology by Health Board in Northern Ireland

	Belfast HSC	South East HSC	Southern HSC	Western HSC
Laparoscopic nephrectomy	Y	Y	Y	Y
Partial nephrectomy	Y	N	N	N
Nephroureterectomy	Y	N	Y	Y
Cystectomy	Y	N	N	N
Radical prostatectomy*	Y	N	N	N
Penile Cancer	N	N	N	Y

**Majority of patients requiring radical prostatectomy are transferred to the Mater Private Hospital in Dublin.*

With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. Recruitment of surgeons with the necessary skills will be the major barrier to expansion of the robotic provision but establishing a second, high-volume robotic service at the Western Trust would appeal to certain individuals and would likely make Western Trust a more attractive place to deliver urology.

Radical prostatectomy; Provision of robotically assisted radical prostatectomy (RARP) is currently predicated on three surgeons operating at Belfast City Hospital. Approximately 56 procedures were performed in 2022 (internal data) with an average length of stay of 1.68 days (England average 1.7 days). Patients requiring RARP from across NI are currently managed on a central register. Because of the numbers involved and constraints on the service, a

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majority of patients requiring RARP are then referred to the Mater Hospital in Dublin for their treatment.

Based on the RARP rate of 150 procedures per million of the population in England, it is estimated that the true requirement for RARP on an annual basis in NI is approximately 270 procedures. It is likely that many patients who are eligible for surgery do not currently choose RARP, either in Belfast or Dublin, and instead opt for active surveillance or radiotherapy as a result of the long waits for the procedure or the need to travel. This is a phenomenon that has been observed in more rural parts of England or where access times are poor.

The average specialist unit in England delivers 150 cases per year with each operating surgeon performing an average of 50 cases per annum. Given NI's requirements, supplying the service would require 6 surgeons in the fullness of time, with back-up support from properly staffed nursing and administrative teams. Based on a two-session day, and two RARP being delivered per list, 120 lists would need to be provided across the network to meet the demand.

The Department of Health needs to urgently work with providers to address the under-provision of theatre capacity for the provision of major urological cancer surgery, thereby addressing delays to treatment. In doing so, there should also be a clear commitment to re-patriate pathways for patients who are currently required to travel out of Northern Ireland for specialist cancer surgery

Cancer Nephrectomy; The majority of renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland and this will further increase the need for robotic surgery provision.

Both open and laparoscopic nephrectomy are provided at 4 Health and Social Care Trusts in NI. Outside Belfast, laparoscopic nephrectomy is the most commonly performed renal operation. Patients with small renal lesions are referred to Belfast for robotically-assisted partial nephrectomy (RAPN) or ablative treatments. The practice is changing rapidly in England. Robotically-assisted nephrectomy and robotically-assisted partial nephrectomy are becoming established as the standard operative techniques, with the more specialised units providing robotic partial nephrectomy and robotic nephroureterectomy. It is likely that nephroureterectomy followed by radical nephrectomy will transition to a robotically-assisted approach as standard in the future, further decreasing the requirement for open surgery. The ratio for partial nephrectomy to total nephrectomy is approximately 70:30.

Based on the available data, NI has a requirement for approximately 180 nephrectomies per year. In a contemporary practice, approximately 125 will be partial nephrectomies and 55 either laparoscopic or open. Partial nephrectomy (RAPN) surgery should only be on a single site, with IR availability. There is a compelling need to improve the provision of nephrectomy across NI (approximately 180 procedures per annum) and robotically-assisted partial nephrectomy at Belfast City Hospital. This should include a networked service for renal surgery as outlined above.

Within the Department of Health, a discussion should be initiated and a strategy will need to be developed regarding the current viability and future provision of the nephrectomy service across NI. Ideally, there should be provision of total nephrectomy across the Province with a single, virtual service linked by a single MDT, so that sickness and holiday leave can be covered. The minimum requirement in the future should be based on at least six trained surgeons providing the range of robotic and open procedures with appropriate governance and oversight.

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Cystectomy; Open cystectomy is currently provided at Belfast City Hospital by three surgeons. There were no data available from the data pack between April 2019 and March 2020, but it is estimated that the annual requirement for cystectomy in NI is a minimum of 56 procedures per year though could be higher depending on disease characteristics. The practice of cystectomy is rapidly changing in the UK and a robotically assisted approach has become the commonest modality in England. By necessity, this change in practice will again need to be factored into a strategic plan for the service; as new consultants take up their posts, most will have completed a robotics fellowship. Radical cystectomy, in common with RAPN, should only be delivered on a single site due to its complexity and lower-case volumes.

There were no concerns expressed in relation to the pathway across NI with respect to cystectomy. Although there is no concrete evidence, there is anecdotal evidence that patients experience significant delays in accessing surgery due to inadequate list availability. Cystectomy is the most time critical pathway in urological oncology and every effort should be made to ensure that patients receive their surgery in a timely fashion (ideally no longer than 30 days from decision to treat). Generally speaking, there will be two patients a week requiring radical cystectomy (when other indications such as pelvic exenteration are included) and the team at BCH should make every effort to regularly provide this capacity and minimise delays in treatment.

There needs to be improved capacity for the provision of radical cystectomy surgery, with adequate and timely theatre access for the delivery of approximately 70-90 procedures per year (based at Belfast City Hospital). Consideration should be given to developing a robotically-assisted approach for this procedure.

Figure 11: Estimated number of urological oncology procedures requiring to be delivered per year in Northern Ireland

Procedure		Estimated number of procedures required /year	Comment
Nephrectomy		180	Based on approximately 70% patient being suitable for partial nephrectomy
	Laparoscopic or open nephrectomy	55	
	Partial nephrectomy	125	
Cystectomy		60-70 (for bladder cancer)	
Radical prostatectomy*		270	
Penile Cancer		25	Many patients will require multiple procedures

Penile Cancer; the penile cancer service is currently based at Altnagelvin Hospital and is essentially staffed by a single consultant with support from an experienced, retired and returned colleague. While this arrangement works well at present there are obvious concerns regarding the resilience of the service in the event of unplanned leave and or sickness. Although the numbers of new penile cancers are relatively small (approx. 30-40 per year), many will require multiple diagnostic and therapeutic procedures. It is important that this service remains linked to a designated penile cancer centre either in North West of England

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or in Eire, both to ensure resilience for this single-handed service and peer support for more complex patients. There is currently a MDT in place with the Christie Hospital, Manchester.

Provision of penile cancer surgery should ideally be based on service delivery by two trained surgeons, ensuring the resilience of the service.

10.2 Stone Management

The current provision of stone service in NI can be shown in **Figure 12.** The advancements in both our understanding of the natural history of stone disease allied with developments in technology over the past decade mean that much stone surgery can be delivered endoscopically using suitably powered lasers; all trusts provide ureteroscopy with the exception of the Northern Health and Social Care Board, which are reliant on an in-reach model at Causeway Hospital, supported by the Urology team from Altnagelvin. Extracorporeal shockwave lithotripsy (ESWL) and the provision of percutaneous nephrolithotomy (PCNL) remain important elements of a contemporary service. In England the numbers of PCNLs performed annually have steadily decreased as better technology means that more patients can be treated endoscopically. ESWL retains an important role in the management of renal calculi and the urgent treatment of patients presenting with ureteric colic. Its' use is supported by NICE guidance, both on efficacy and cost comparison.

Figure 12: Current provision of stone services in Northern Ireland

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Site(s)	Royal Victoria and Belfast City	Causeway	Ulster and Lagan Valley	Craigavon and Daisy Hill	Altnagelvin
Ureteroscopy and laser fragmentation	Y	Y	Y	Y (CAH + DHH)	Y
PCNL	Y	N	Y	Y (CAH)	Y
ESWL	Y	N	N	Y (CAH)	Y

The provision of PCNL is dependent on securing a suitable access track with radiological screening, either performed by the operating surgeon or more commonly an interventional radiologist. The number of patients requiring PCNL in Northern Ireland is small and it is generally agreed that the service should be placed in one hospital, helping to free up theatre time in other units. The agreed model is that centralisation of PCNL surgery and more complex endourological procedures should take place at Craigavon Area Hospital, led by the Southern team. This will require the provision of an all-day operating list for PCNL, supported and funded for a minimum of 42 weeks of the year with two PCNLs on each list. Case volumes for the more complex endourological procedures will also need to be assessed as these will require additional theatre capacity within the unit.

Centralisation of static ESWL should also take place at Craigavon Area Hospital; this will require the provision of ESWL 5 days a week, supported by trained radiographers and clinical staff (including a dedicated clinical nurse specialist). There should be a single referral system in place for all Trusts to enable timely access to both acute and elective ESWL. Such an arrangement will enable the Department of Health to disinvest in mobile lithotripsy services.

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Each trust providing an emergency service must ensure there are established pathways for the provision of urgent ureteroscopy and/ or ESWL. Such models of care work well elsewhere in England. For ureteroscopy and laser lithotripsy, this can include a 'book and return' model to the acute site or a HVLC hub site.

10.3 Female and Functional urology

Due to the pressures on core urology, emergency care and limited theatre access, the provision of female and functional urology has struggled for in NI for many years. The Covid pandemic has exacerbated poor access to care for these patients and many women with stress urinary incontinence and other functional issues have had difficulty accessing appropriate surgery.

Figure 13: Current provision of female and functional procedures in Northern Ireland

Procedure /Condition	Current provision(Urology)	Comment
Surgical management of urinary stress incontinence	Belfast City, Craigavon and Altnagelvin	Element of this service should be provided in association with urogynaecology at designated sites
Vesicovaginal repair (VVF)	Altnagelvin and Belfast City and Craigavon	Altnagelvin
Ureteric injury **(Trauma and iatrogenic)**	All centres	Constraints in theatre access at BCH and long waits hamper the service
Bladder augmentation	Altnagelvin and Belfast (in-reach)	As above
Urethral reconstruction*	Altnagelvin	As above
Insertion of artificial urinary sphincter	Not currently commissioned or provided in N Ireland	Service could be provided in a 23-hour surgical unit. Altnagelvin may be best placed to consider this.
Congenital and acquired neuropathic bladder management	Belfast City, Altnagelvin and Craigavon	Provision of services for these patients (including those with MS) occurs on an ad hoc basis
Videourodynamics	Altnagelvin and Belfast City	New facilities developed at Belfast City

*Linkage to sub-specialty MDT

There have, however, been pockets of good care and positive developments in Northern Ireland. The best developments have been at Altnagelvin where video-urodynamics (used to establish a diagnosis with bladder pressure monitoring, combined with radiological imaging) and sacral nerve stimulation (SNS) have been commissioned and are providing a good service for the region. As seen in **Figure 13**, provision of surgery for urinary stress incontinence

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(provided by a Urology service) is delivered at Belfast, Craigavon and Altnagelvin. Surgery for Genuine Stress Incontinence (GSI) is also provided by urogynaecologists across Northern Ireland and it is difficult to get precise estimates about how much is being done by each specialty.

Surgery for female and functional problems unfortunately occupies a low priority for many busy hospitals. This is evidenced by the situation at Belfast City and Craigavon where, despite having an Urologist trained in this area of practice, access to theatre is constrained by the unmet demand of the oncology service. This situation is unlikely to be resolved for the foreseeable future. Patients continue to be referred to Belfast City Hospital without a realistic timeframe for surgery.

Compounding this issue is the requirement to deal with other aspects of functional urology which can have a profound effect on patients' lives. These include the surgical management of intractable incontinence, and the long-term management of patients with congenital neuropathic bladder and other neurological issues which affect bladder function (e.g. iatrogenic trauma, MS, stroke, spinal cord injury and vesico-vaginal fistula). Belfast Health and Social Care Trust is the designated Mesh Centre for management of patients with vaginal tape erosions, which requires a combined urogynaecology, urology and pelvic surgery input. While the clinical expertise is available, surgical facilities underpinning activities in functional urology are inadequate to meet current demands. Surgical techniques have developed significantly over the past decade and internationally more of these patients are being managed using robotic techniques, which are destined to become standard management in the next decade. They should be equally available to patients from Northern Ireland. Currently the robot is only commissioned for radical prostatectomy and partial nephrectomy.

Due to the small numbers involved, elements of female and functional urology for NI should be properly commissioned and resourced. Options include limiting investigative and surgical options to one or two centres in the province or considering disinvesting from some elements of the subspecialty (e.g. urethral reconstruction, mitrofanoff procedures). There is little or no prospect of this service being delivered at the City Hospital in Belfast and alternative site(s) must be identified for the provision of care within six months.

10.4 Andrology (including Urethral Reconstruction)

Access to benign andrology and urethral reconstruction surgery in Northern Ireland has been extremely limited over the past few years due to the huge pressures elsewhere in the service, including the long cancer waits, the Covid pandemic and limited theatre access. Northern Ireland has one trained andrologist for the region who is fully committed to delivering a high quality penile cancer.

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Figure 14: Estimated Andrology Requirements for Northern Ireland

Procedure	Rates per 100,000 in UK practice*	Anticipated requirement per year in NI (based on population of 1.868 million)
Artificial urinary sphincter insertion	0.63	12
Penile prosthesis insertion (new)	0.44	8
Urethral surgery (including hypospadias repair)	4.2	79
Urethral surgery (excluding hypospadias repair	1.08	20
Penile cancer procedures	0.66	13
Corporoplasty	0.77	15
Male Infertility procedures	0.69	13

The projected andrology requirements for Northern Ireland are shown in **Figure 14**, based on current UK data. In Northern Ireland, at present, two consultants provide urethral reconstruction, but the bulk of their work is in the provision of core urology, stones and emergency care. As a consequence, patients with urethral stricture disease can wait significant periods of time for definitive treatment.

In the England, andrology services are largely predicated on a population of 7 million and the number of surgeons with a low volume practice in the subspecialty has declined significantly over the past few years.

At a minimum, andrology services for NI should be properly commissioned and limited to single centre. However, the anticipated volume of procedures is low and does not lend itself to the development of genuine subspecialty expertise. The Department of Health should commission a review of surgical andrology for NI. Options for the service might include:

1. Centralise the provision of surgical andrology at Altnagelvin hospital. This would require an expansion of current commissioning, an increase in surgeons providing the service (challenging both in terms of geography and identifying the right personnel) allied with increasing specialist nurse support.
2. Centralise the provision of surgical andrology at the Ulster and Lagan Valley Hospital. Much surgical andrology can now be delivered using a 23-hour facility; services would need to be developed at the Lagan Valley Hospital to support this. It would also require an expansion of current commissioning, an increase in surgeons providing the service allied with increased specialist nurse support.
3. Disinvest in the provision of benign surgical andrology and refer patients to units in Ireland or England.
4. Examine the feasibility of a solution based on a population of 7 million.

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Annex A - Full list of hospitals

Trust	Hospital
Northern Trust	Antrim Area Hospital
	Causeway Hospital
	Mid Ulster Hospital
	Magherafelt Hospital
Western Trust	Altnagelvin Hospital
	Omagh Hospital and Primary Care Complex
	South West Acute Hospital
	Roe Valley Hospital
	Limavady Hospital
Southern Trust	Craigavon Area Hospital
	Daisy Hill Hospital
South Eastern Trust	Ulster Hospital
	Lagan Valley Hospital
Belfast Trust	Belfast City Hospital
	Mater Hospital
	Royal Victoria Hospital

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Annex B - Southern Health and Social Care Trust Findings and Recommendations

Findings	Recommendations
Workforce	
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff.
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave and professional leave.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in

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	advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.
Current provision of Mitomycin-C is problematic	In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be

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	used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley facility.
Specialist services	
Stone service.	It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list).There will need to be additional capacity for other types of complex endourological stone procedures.
ESWL.	The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.
There is currently under-provision of benign andrology surgery across NI.	Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin Hospital.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

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Annex C - South Eastern Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing team is under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles.	Subject to funding, the Clinical Nurse Specialist (CNS) team should be expanded further as a priority area of development for the Trust. Their roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established. Given the expansion of bladder outlet surgery services, a CNS should be employed to manage the lower urinary tract symptoms (LUTS) pathway.
There are two physician's associates (PAs) in post in the unit and there is significant scope for them to support service delivery in both acute and elective care.	The department should refer to the new Urology PA curriculum that has been developed as well as the GIRFT Academy UIU guide to map out the career development plan for the PAs and how they will contribute to the long-term vision for the service.
The unit only receives 1 NTN trainee per year but there is significant scope to offer more training within the unit (*e.g*. training in BOO surgery at Lagan Valley).	The TPD for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
The protected elective capacity at Lagan Valley is an impressive development, led by the South Eastern Trust but also utilised by Southern and	The Lagan Valley facility warrants continued support and expansion of capacity. It is a key component of elective recovery. Likewise,

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Belfast teams. It has enhanced the day case opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	investment in any further technologies that are required is likely to be good use of resources with the opportunity for patients across NI benefitting from this excellent service. The South Eastern team should continue to lead on development of the networked BOO surgery service across NI.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting. Lagan Valley Hospital would be a good site for this service, based in a procedure room.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway should be developed further at Lagan Valley Hospital and become the default pathway for patients who are suitable for a day case approach.
Radical nephrectomy is provided by a single surgeon at the Ulster Hospital. Patients requiring partial nephrectomy are referred to BCH.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent

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	from work for other reasons. This will also mitigate against differences in access times should they occur.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the excellent work that has already been done on the BOO surgery service to date.
Specialist services	
There is currently under-provision of benign andrology surgery across NI.	There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin.
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

Received from SHSCT 01/12/2023 Annotated by the Urology Services Inquiry.

Annex D - Belfast Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
For a major cancer centre, the specialist nursing team is grossly under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles, once staffing levels are improved.	The CNS team should be expanded further as an urgent action for the Trust. A cancer centre serving 1.8 million people would be expected to have a CNS team that is sub-specialised, with each CNS having a specific area of interest (bladder, kidney, prostate and penile / testicular). They should be able to cross-cover colleagues. Nursing roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The current consultant complement is currently understaffed to provide the cancer services with respect to robotic prostatectomy, cystectomy and elements of renal cancer surgery	The trust should expand the number of consultants to provide urological surgical oncology for Northern Ireland subject to funding.
Cross-site working is challenging for the Belfast team as they are required to cover both the City Hospital and the Royal Victoria Hospital.	Expansion of middle grade support is needed to support the delivery of emergency care and to alleviate some of the issues associated with split-site working. A modern, middle grade workforce should include extended roles such as physician associates or nurse practitioners.
Outpatients and diagnostics	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as	A TULA service should be implemented promptly. It is a low-cost innovation with a

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an outpatient under local anaesthesia using TULA.	short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC site	
There can be difficulties in offering timely treatment for patients requiring less major forms of surgery (for example, TURBT). This is due to the pressures associated with the major surgery workload.	The day case TURBT pathway should be developed further, with consideration given to using the facilities at either the Mater Hospital or at Lagan Valley Hospital. Daycase TURBT should become the default pathway for patients who are suitable for a day case approach. Decompressing the service at Belfast City Hospital would help to alleviate pressures and ensure more equitable access to surgery for patients.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Every effort must be made to ensure that suitable patients get access to intravesical Mitomycin at the time of their surgery.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Addressing the waiting time for men with lower urinary tract symptoms should be a priority for the trust. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of elective BOO surgery should be focused on the South Eastern team, which will also alleviate some of the pressures in Belfast due to the major cancer workload.
Oncology	
Theatre provision is wholly inadequate for the delivery of major urological cancer surgery in N Ireland. There are long delays to treatment and a high proportion of patients needing specific forms of cancer surgery (radical prostatectomy) are required to travel to Southern Ireland for their care. A DaVinci robot is available, with trained surgeons, but it is significantly under-utilised.	There is the clinical expertise to be able to offer the full range of surgical treatment options to patients from across NI, diagnosed with urological cancer. The prime reason that patients are currently delayed in their care or having to travel elsewhere is due to the lack of theatre facilities at Belfast City Hospital. All specialties are competing for theatre access in a highly constrained environment comprising only 5 functioning operating theatres. This capacity gap needs to be urgently addressed and this report includes estimates of the capacity that is required to make the service self-sufficient and able to treat the

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	population without the need to travel out of NI. Trust management to ensure the robot is utilised throughout the week, given the volume of robotic surgery that needs to be performed. Subject to funding, serious consideration needs to be given to a second robotic service in Altnagelvin Hospital, as Belfast Trust is clearly not in a position to accommodate the required expansion of services necessary to meet the population need. Robotically-Assisted Partial Nephrectomy (RAPN) and radical cystectomy should remain on a single site but robotic-assisted laparoscopic prostatectomy (RALP) and other renal surgery could be performed across two sites with robust MDT and governance arrangements. The Trust need to be extremely cautious of expanding robotic programmes into new surgical specialties ahead of addressing their capacity for the treatment of patients with urological cancer, where robotically-assisted surgery is the standard of care for major urological cancer. DN this needs to be moved to WHSCT or as a regional recommendation
There is expertise in the delivery of more complex aspects of major kidney cancer surgery.	The Belfast team should participate in the formation of a virtual MDT with colleagues undertaking single-handed, laparoscopic nephrectomy across NI to ensure equitable access to surgery in the event of consultant annual leave / unexpected absence.
Urgent and emergency care	
The Royal Victoria Hospital lacks an ambulatory area for urology and patients are initially directed to ED from primary care.	For a centre of this size, the Royal Victoria Hospital should have a dedicated ambulatory area for the management of patients with urological conditions requiring urgent and emergency care. Patients should not be directed to ED from primary care or other centres. This is inappropriate and they should be managed through an ambulatory unit.
There is currently a postcode-based system for patients who attend Antrim Area Hospital, with	It is our recommendation that the current postcode-based system is removed and the

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an overly complex arrangement that extends to Altnagelvin Hospital. It is not conducive with safe patient care and there needs to be greater ownership of this issue by a single provider.	arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital (see Western recommendations).
Patients requiring admission are currently admitted to a ward that is predominantly focused on orthopaedics and not overly experienced in urological care.	The current ward setting is not working well for the provision of admitted emergency care for patients with urgent urological conditions. The Trust needs to urgently develop a more suitable ward base in order to meet this need.
There are no offices available to the Urology team on the Royal Victoria Hospital site, where the majority of acute services are delivered.	The clinical team should be provided with access to adequate office facilities to allow them to undertake their administrative work whilst on call.
Further improvements could be made with regard to the management of acute stone patients. This should include improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy, offering suitable patients treatment at Royal Victoria Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men presenting with acute urinary retention face long delays in getting access to appropriate treatments.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of BOO surgery should be focused on the South Eastern team, which has the potential to alleviate some of the pressures in Belfast due to the major cancer workload.
Specialist services	
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.

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Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust.
Because of the pressure on theatre space at Belfast City Hospital, there are long delays for patients requiring benign reconstructive surgery.	Greater use should be made of HVLC sites (Lagan Valley Hospital (day case) and potentially the Mater Hospital for the delivery of short stay (23 hours) female and functional urology For patients requiring more complex surgery, services should be developed at Altnagelvin Hospital with an in-reach model

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Annex E - Western Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing workforce is a strength at Altnagelvin Hospital, with CNS's delivering flexible cystoscopy, LUTS assessment clinics, ED clinics and cancer follow-up clinics.	Subject to funding, the CNS team should be expanded further as a priority area of development for the Trust. Their roles should be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of NTNs accredited each year.	The department should continue to address barriers to recruitment, where these are within their control. This would include a more robust middle grade rota of cover for on-call as the current consultants are largely the first point of contact for four acute Trusts (Causeway, SWAH, Antrim and Altnagelvin). A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff. Please see below regarding robotic surgery. The Department of Health should also consider incentivisation of terms and conditions in the Western Trust, in order to attract consultants into the area.
Outpatients and diagnostics	
Waiting access times for outpatients at the Western Trust are the best in NI (see Figure 5). The team are to be congratulated on this, particularly given the lack of dedicated outpatient facilities highlighted below.	Learning from the Western Trust should be shared with other sites to understand how the waiting times can be improved at other Trusts.
Accommodation for medical and nursing staff is inadequate with cramped facilities and poorly linked to other clinical areas.	Please see the recommendation on development of a UIU.
Outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are wholly inadequate and are of the lowest standard of all the urology units in NI. They are also disparate in terms of their location throughout the Trust. It will remain difficult provide efficient and timely outpatient care	The Trust needs to urgently develop and deliver plans for a co-located UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work. A UIU is the ideal place to provide office

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without urgent investment and re-design of facilities.	accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC sites	
Theatre facilities at Altnagelvin Hospital are inadequate, with the majority of operating lists being offered in a theatre that has been decommissioned previously, on more than one occasion. The theatre footprint is too small for a modern operating theatre and cannot safely accommodate the patient, the staff and the wide array of urological equipment that is needed to undertake contemporary urological surgery.	There need to be urgent plans for the provision of suitable operating theatres for urological surgery. A majority of such surgery can be performed in daycase facilities, with a smaller component requiring in-patient care (usually due to patient co-morbidity or case complexity). It is not acceptable to continue delivering surgery in the existing facilities in the medium to long term.
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	As a minimum, each consultant needs access to a main theatre for 2 sessions per week 42 weeks of the year.
Minor and intermediate procedures continue to be undertaken in theatre at the Causeway Hospital but the set-up is highly inefficient. The team have not been given access to daycase beds and problems with patient flow means that start-times of 10.30am or later are common. The lists are poorly utilised in terms of volume of work.	Elective surgical work at the Causeway Hospital should be reviewed with consideration of future provision in-house at Altnagelvin Hospital or Omagh.
Flexible cystoscopies are being performed in theatre at the Causeway Hospital.	This practice needs to stop and should be provided in an outpatient setting by default. It is an inappropriate use of a theatre environment.

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Oncology	
Given the significant shortfall in the ability of Belfast Trust to provide the necessary resource for major cancer surgery, serious consideration needs to be given to a second robotic platform at Altnagelvin Hospital.	With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. At present, only 50 of an estimated 250 men undergo RALP in Belfast and our predictions are that the province needs 5-6 RALP surgeons across the two sites if it is to meet this need. Renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland. Recruitment of surgeons with the necessary skills will be the major barrier but establishing a high-volume robotic service at the Trust would appeal to certain individuals and make Western Trust a more attractive place to deliver urology. It would also complement the facilities that are provided at the oncology centre for patients requiring radiotherapy or chemotherapy. This development could be critical in ensuring long-term viability of the urology service in the West. Implementation of this recommendation will be subject to funding.
Radical nephrectomy is provided by a single surgeon at Altnagelvin Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons. This will also mitigate against differences in access times should they occur.
Altnagelvin Hospital is the referral site for penile cancer services in NI. It is predominantly a single-handed practice with over 75% of the consultant's theatre capacity being used this work. For this reason There is very little benign work being performed.	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage. To mitigate the risks associated with single-handed practice, the unit needs to have a close-working

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	relationship with services on the mainland. This is currently at The Christie NHS Foundation Trust in Manchester.
Urgent and emergency care	
Urgent and emergency care pathways are not functioning consistently across the Trusts that sit within catchment for the Altnagelvin on-call team. This is particularly true in regard to the Trusts in the Northern sector (Causeway and Antrim) but also applies to South West Acute Hospital (SWAH). As a result, there is significant variation in the provision of acute urological care leading to postcode variation for patients.	Urgent action is needed to clarify these pathways and agree the arrangements for the provision of urgent and emergency care. The Urology Teams at Altnagelvin, in association with General Surgery and ED colleagues in the Northern Trust and Belfast Health and Social Care Trust, should develop contemporary clear protocols and care pathways for Urology patients requiring transfer and onward specialist urological treatment. These should include pathways for acute ureteric colic, urinary retention, haematuria and urosepsis management. It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital.
Interventional radiology provision is predicated on a single radiologist and is predominantly only available 'in-hours'. There are plans for an outreach, networked model later this year supported by Belfast Trust.	Ensure there is a clear protocol in place with associated access arrangements for the provision of interventional radiology, including out-of-hours cover.
Improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for suitable patients. A seamless referral pathway needs to be agreed between the Western team and Craigavon Area Hospital.
Specialist services	
While andrology surgery is offered at Altnagelvin Hospital, the service is reliant on a single surgeon and with the pressures of the penile cancer service, there is little time or resource available for the service	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage.
Stone service	It has been agreed that ESWL and PCNL surgery will be centralised at Craigavon Area Hospital.

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Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery pathway at the Lagan Valley facility. There should be a networked approached to this service.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.
Other observations	
The clinicians cited a disconnect between the previous management team and the clinical team, with a lack of business meetings since the initial COVID surge. It was felt that there was still some work to do to ensure the current relationships functioned well.	There should be a regular (monthly at least) meeting between the clinical team and the service management team, with opportunities to link in with more senior managers and executives. Meetings should have formal agendas, minutes and actions. Actions should be reviewed at each meeting.

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Annex F - Northern Trust Findings and Recommendations

Findings	Recommendation
Workforce	
The community continence team nursing team is under-resourced and communication with the Urology teams at Altnagelvin Area Hospital and Belfast City Hospital is patchy.	Strengthening the links between the community team and urological services would enable better access to urological services (e.g. LUTS treatment and Stone management) for patients .
Outpatients and diagnostics	
Patients are traveling long distances to either Belfast or Derry for outpatient consultations	A priority for the Trust should be the further development of the UIU at Whiteabbey. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place enabling patients to be seen and managed without having to travel into Belfast
Facilities including HVLC sites	
Under-utilisation of Urology daycase facilities at both Causeway Hospital and Antrim Area Hospital.	Given the current shortage of urological in the Western Health Trust a review of elective urology at Causeway should be undertaken. Better use of the daycase facility at Antrim Area Hospital aligned with GIRFT principles should be introduced.
Urgent and emergency care (UEC)	
There is no on-site provision of specialist urological care in Antrim Area Hospital or Causeway Hospital. Initial triage and care for common urological conditions (including torsion) is provided by the acute general surgical team. A percentage of patients also end up being cared for by physicians on the medical wards. Depending on a patient's postcode, patients requiring onward urological care are referred to either Altnagelvin Hospital or Belfast Trust. A number of concerns were raised by the local teams (represented by ED, general surgery, medicine and anaesthesia at the site visit). • There were no clear protocols in use for the management of common urological conditions. • Although advice could be sought from the urology on-call team at Altnagelvin or Belfast Trust, specific management plans were not always clear. • 'Admit locally' was said to be a common initial instruction from the on-call team to	It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin. As a matter of urgency, senior clinical leaders from the relevant specialties at each Trust should meet and agree the re-configuration of services. There needs to be clear protocols in place for the common urological emergencies. As a minimum, these should include pathways for urosepsis, haematuria, acute ureteric colic, urinary retention and epididymo-orchitis. The focus should be on ambulatory models of care, where safe to do so. There should be explicit guidance as to how patients could be reviewed at Belfast Trust for longer-term management plans or subsequent attendance at urology ambulatory assessment units.

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ED / acute take, leading to further calls between hospitals to clarify the plans for onward care. • When transfers were required, they were often delayed and subject to site meetings between the referring and receiving Trusts. • There was consensus that patients requiring urological input were not receiving the same timely input or urological oversight that patients in the urology units had access to.	Operational site teams should be part of these discussions, to agree how patient transfer can be optimised in order to mitigate against delays in specialist urological input. The urology on-call team at the receiving unit(should ensure that clear plans are given for immediate care of the acute urology patients as well as clear advice on what follow-up is required and how that will be arranged. Following introduction of these pathways, a follow-up meeting between clinical leads should take place after 3 months to check that they are effective in delivering safe urological care in the acute setting.
Oncology and Subspecialist Urology	
When patients who had undergone oncological procedures performed at another trust presented with complications, there were unnecessary delays in transferring patients.	A SLA and clear pathways should be rapidly instituted to enable the swift transfer of patients requiring specialist urological care.
Other	
Clinicians and senior managers present at the site visit could not recall any recent meetings between clinical leads at each Trust to address issues of mutual concern.	Given the issues raised in this review, it would be sensible to schedule an annual meeting between senior clinical leaders across the Trusts to ensure ongoing oversight and governance.

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Annex G: Useful links to GIRFT Urology Pathways and Good Practice Guidance

To access the documentation, please click on the links below.

1) NHS England - Model Hospital
2) GIRFT National Urology Report
3) Diagnostics: Recovery and Renewal Report.
4) MedTech Funding Mandate policy 2022/23: guidance for NHS commissioners and providers of NHS-funded care
5) Day case surgery rates
6) GIRFT Good Practice Guide for Urology
7) Clinically-led Specialty Outpatient Guidance
8) Urology Outpatient Transformation
9) Urology: Towards better care for patients with bladder cancer
10) Urology: Towards better care for patients with acute urinary tract stones
11) Urology: towards better care for patients with bladder outlet obstruction
12) Urology: the path to recovery
13) Specialised kidney, bladder and prostate cancer services.
14) Minor peno-scrotal surgery pathway
15) Cystoscopy plus (rigid cystoscopy, endoscopic lower urinary tract procedures)

Received from SHSCT 01/12/2023 Annotated by the Urology Services Inquiry.

Annex H: Glossary of Terms and Abbreviations

Abbreviation	Term
A and G	Advice and guidance
BADS	British Association of Day Surgery
BOO	Bladder outflow obstruction
BPH	Benign Prostatic Hyperplasia
Bladder reconstruction	A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.
CEPOD	Confidential enquiry into Peri-operative deaths; CEPOD lists are a means of prioritising patients for surgery, based on clinical need
CNS	Clinical Nurse Specialist
Cystectomy	Surgery to remove all or part of the bladder.
Cystoscope	A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.
ED	Emergency department or erectile dysfunction
ESWL	Extra-corporeal shock wave lithotripsy
GIRFT	Getting it Right First Time
GSI	Genuine stress incontinence
Haematuria	The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.
HES	Hospital Episode Statistics. HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.
HoLEP	Holmium enucleation of the prostate; surgical treatment for BPH
HVLC	High volume low complexity
LATP	local anaesthetic transperineal (prostate biopsy)
LUTS	lower urinary tract symptoms
IR	Interventional radiology
Laparoscopic surgery	Surgery performed using a laparoscope; a special type of endoscope inserted through a small incision in the abdominal wall.
MRI	Magnetic resonance imaging. A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).
MDT	Multi-disciplinary teams
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health Care Excellence
NIEPC	Northern Ireland Electronic Patient Care
NIMDTA	Northern Ireland Medical and Dental Training Authority
NTN	National training number
PCNL	Percutaneous nephrolithotomy; key hole surgery on the kidney to treat renal stones
Prostatectomy	Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.
PA	Physician Associate

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PAE	Prostate artery embolisation
RARP	Robotically-assisted radical prostatectomy
PIFU	Patient initiated follow-up
Rezum	Surgical treatment for benign prostate enlargement
RNOH	Royal National Orthopaedic Hospital
PSA	Prostate Specific Antigen
RTT	Referral to treatment time
SLA	Service level agreement
SOP	Standard operating procedure
SNS	Sacral nerve stimulation (treatment for refractory bladder over-activity)
TP	Trans perineal (as in transperineal biopsy)
TPD	Training Programme Director
TRUS	Tran-rectal ultrasound
TULA	Transurethral laser ablation
TUR	Trans-urethral resection
TURBT	Transurethral resection of bladder tumour
TURis	Trans-urethral resection in saline
TURP	Trans-urethral resection of the prostate (TURP); Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.
TWOC	Trial without catheter
UAN	Urology Area Network
UEC	Unplanned and emergency care
UIU	Urology Investigation Unit
Urolift	Surgical treatment for benign prostate enlargement
VVF	Vesico-vaginal fistula (an abnormal communication between the bladder and vagina)
WTE	Whole time equivalent

Received from SHSCT 01/12/2023 Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Southern HSC Trust
Getting it Right First Time
Urology

Southern Trust Recommendations
Action plan updated 23rd May 2024

RAG rating	No. of actions
	10 (56%)
	6 (33%)
Both regional	2 (11%)

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

WORKFORCE					
RECOMMENDATION 1					
The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an Developing areas of sub-specialist practice can also aid recruitment and retention of staff.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	Cathrine Reid / Mark Haynes	Since the GIRFT Visit in March 2023 the Urology Team have advertised for the following medical staff: • Specialty Doctor – Commenced Aug 2024 Temp initially until recurrent funding is secured • International recruitment – successfully appointed 3 Urology Consultants. Commencing 1 x Feb 24 and 2 x April 24 • Physician Associate – advertised, offered and declined. Back out to advertise. Temp initially until recurrent funding is secured • Urology CNS – non-recurrent funding received for 1.8wte, 0.8wte in post. Recurrent funding in IPT We will continue with one Locum Consultant until all Substantive Consultant posts are filled.	Complete		

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

RECOMMENDATION 2					
The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	Mr Tony Glackin	Southern Trust trainees get appropriate learning experiences in SHSCT as evidenced at ARCP and national training survey. The Urology consultants insist on the trainees following a defined job plan. Additional national trainee numbers were created. At this time a process was undertaken by NIMDT where by proposed additional SPR placement proposals from each Trust were objectively accessed and ranked in order to determine the placement of the additional numbers. Wider recommendation than the Southern Trust	complete		

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

Facilities including HLVC Site					
RECOMMENDATION 3					
Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Cathrine Reid / Lynn Lappin / Wendy Clayton	The Thorndale Urology Unit is specifically for the Urology Services. It comprises of 9 consultation rooms and 2 treatment rooms. All consultation rooms are flexible to allow procedures such as bladder scanning/difficult catheter changes/ Haem clinics etc Treatment rooms are available for TP Biopsies and Urodynamic Clinics. Post covid there were 2 specialities outside of urology using the outpatient rooms as these were not occupied due to medical vacancies. However, since recruitment the Thorndale Unit is occupied solely by Urology Services In addition we have created 2 additional outpatient rooms just outside Thorndale Unit for overflow of outpatient clinics if required	Complete		

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 4					
Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Cathrine Reid / Declan	The Urology surgeons from August 2023 have their job planned theatre sessions per week, the service is back to full funded sessions We are delivering the full Urology funded theatre sessions by Urology Consultants from other Trusts backfilling if theatre is available In addition ST provide 2 theatre sessions in Lagan Valley Hospital All Urology Consultants deliver Urologist of Week which is 35 weeks of clinical activity. With 7 consultants and staff grade; as well Belfast Trust using theatres in ST the urology team aim to deliver 11 theatres per week	Aug 2023		

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

RECOMMENDATION 5					
The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	Mark Haynes / Wendy Clayton	The Southern Trust does send an operator to Lagan Valley Hospital each Wednesday approx 48 weeks of the year	Complete		

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

Outpatients and diagnostics					
RECOMMENDATION 6					
There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.					
	Responsible Director	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	Cathrine Reid / Barry Conway / Lynn Lappin / Mark Haynes/ Wendy Clayton	Suspected Prostate cancer pathway is currently being reviewed regionally as part of NICAN and also being considered along with the Regional Diagnostic Centre (RDC) project There is a meeting arranged Wed 10 Jan 24 between Cancer, Radiology and Urology team to discuss and consider a Prostate RDC pathway Commissioning assistance will be required to achieve this recommendation However, Southern trust would welcome discussion regarding haematuria and whether imaging prior to flex cyst is more efficient from a provision perspective than imaging at the time of attendance	Est. Dec 2024		

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		Encourage pathways by using Physician Associates i.e. imaging prior to flex cyst. To be discussed through Regional PIG meeting **April 24**- NICAN are undertaking a scoping exercise to capture potential future pathways with the RDC centres. **May 24** - Mr Haynes spoke with Radiologist last Thursday 25 April 24, he is pulling this together and has also starting liaising with the Northern Trust team.			

RECOMMENDATION 7					
Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Barry Conway/ Denise Newell / Geoff Kennedy	12/12/23 Prostate pathway snapshot Date for MRI scan – decision to biopsy = 14 days	Completed		

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		MRI imaging is included in the pathway streamlining process in Recommendation 6 Currently there are 57 MRI prostates on the waiting list – 24 of these are prioritised as red flag – all of these are appointed with the exception of 1 and only one is currently waiting over the 2 weeks. From a reporting perspective on average 40.5% of red flag and urgent examinations are reported within 2 days. There are additional radiologists that have been trained up to report in this area however, with ongoing demands across the system it is difficult to increase this at the moment.			

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Oncology					
RECOMMENDATION 8					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	Mark Haynes / Wendy Clayton	Funding has been received from SPPG and 1 xTULA equipment ordered Outpatient Sister has advised that the TULA has arrived and waiting on estates asset ID label. They have been emailed again last week about it. Currently waiting on the delivery of accessories to go with the TULA 2 x CNS's are going to a training session in January 2024 in London – flights were cancelled due to storm Updated April 24: CNS's to arrange a visit to BCH or Lagan Valley for training once they have the TULA service embedded. Jane Brown the Laser Protection Adviser to visit TDU on Thursday 25th April to look at the flexi room and to advise on adjustments needed.	Sept 2024		

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		25/04/2024- the CNS has been in contact with the rep from pro med to look at another academic day on TULA. The CNS will arrange a visit to BCH or Lagan Valley for training once they have the TULA service embedded. CNS has arranged for Jane Brown the Laser Protection Adviser to visit TDU on Thursday 25th April to look at the flexi room and to advise on adjustments needed.			

RECOMMENDATION 9					
The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Mark Haynes / Helena Murray	Urology moved to DHH theatres during COVID and remains there present day Previously, Urology services were in CAH main theatres only and would not have operated in DHH. Therefore, theatres	Est April 2024		

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		nursing team will require training and protocols drawn up Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24) Implementation and mitomycin being given in DHH theatres			

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RECOMMENDATION 10					
In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Current provision of Mitomycin-C is problematic	Declan McClements / Helena Murray	See recommendation 9 Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24) April 24- email sent to Declan for an update and progress Implemented in DHH theatres	Sept 2024		Green - Partial implementation in DHH

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 11					
The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-					
Original Findings	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	Mark Haynes	This is a regional recommendation. From a Southern Trust perspective 2 substantive Urology Consultants provide radical nephrectomy and from Sept 2023 patients have been transferred from Belfast to Southern Trust waiting list due to long waiting times in Belfast Trust for robotic procedures. To provide capacity in Belfast for robotic take radical nephrectomy from Belfast to Southern Trust A renal cancer project had been initiated in early 2023 with the support from NICAN A regional meeting took place in October 2023 where region wide	Regional timescale re single MDT implementation		Green – 3 surgeons in Craigavon providing radical nephrectomy from Sept 2023 (Surgeons – AJ Glackin, M Evans and MD Haynes) Amber – no single MDT at present

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		agreement for a single region waiting time was agreed This subsequently has been discussed through the PIG group with the view to implementation over the next 3 months			

Urgent and Emergency Care					
RECOMMENDATION 12					
The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	Cathrine Reid / Lynn Lappin / Wendy Clayton / Mark Haynes	Regional recommendation: Regionally to look at capacity and demand for ureteroscopy patients to establish if LVH Pilot Southern Trust for book and return (Ambulatory 'hot' ureteroscopy patients)	Est April 2024		

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		Once established Southern Trust would be happy to utilise and partake in delivery There is a regional access to the Southern Trust Regional ESWL service (elective and emergency)			

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Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 13					
The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Mark Haynes / Wendy Clayton	There is currently an agreed route for patients from ED into the outpatient urology service for trial removal of catheter and subsequent through the Lower urinary tract symptoms (LUTS) / Bladder outlet obstruction (BOO) nurse specialist service which already dovetails with the available daycase bladder outlet surgical options in NI. The pathway could be improved and discussions have commenced with ED with a view to improving the pathway, however, the biggest challenge to delivering a timely service is capacity	June 2024		No issue in the Southern Trust. Patients have catheter removed within timeframe following procedure

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Specialist services					
RECOMMENDATION 14					
It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list).There will need to be additional capacity for other types of					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Stone service.	Cathrine Reid / Lynn Lappin / Declan McClements Mark Haynes / Wendy Clayton	The Southern Trust has submitted an IPT for the ESWL and is finalising an IPT for PCNL service **ESWL** – regional service has commenced, including both elective and emergency ESWL procedures region wide. **PCNL** – the regional PCNL surgery sessions have commenced in the Craigavon Hospital but using Southern Trust core sessions. 2 consultants from Belfast Trust come to CAH to undertake long waiting PCNL surgery First international recruit Urology Consultant will be running PCNL theatre sessions once through induction	August 2024		Green – ESWL is established Amber – plans in place, local waits of PCNL have been stabilised.

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		From next summer operators will increase once by potentially a further 2 PCNL operators Allocation letter received April 24 to increase PCNL theatres. Letter circulated to ST team to commence recruitment			

RECOMMENDATION 15					
The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
ESWL.	Cathrine Reid / Lynn Lappin / Barry Conway	The ESWL currently has 4 patients AM and 3 patients PM per session When radiographers are recruited this will increase to 4-5 patients per session Interviewing Dec 2024 with estimated start date of March 2024 Allowing 1 slot per day for emergency • 5 AM slots – one for emergency • 4 PM slots	April 24		

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Getting it Right First Time, Urology, Southern Trust

		Cancellation is usually a 2nd treatment **April 24 update** – Radiographer 8a recruited and appointed, commenced end of March 24. New litho machine installed end of March/ early April 24. Training has commenced.			

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RECOMMENDATION 16					
Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
There is currently under-provision of benign andrology surgery across NI.	Mark Haynes	The Southern Trust agree that benign andrology should be a specialist service undertaken by a small team as a regional service, ideally co-located with the penile cancer service, and utilising regional day case facilities where appropriate. Penile straightening surgery for example, has not been undertaken by any of the Southern Trust team for a number of years and none of the team are in a position to be able to offer this surgery. There are currently a number of patients on the waiting list for this surgery and we have no means of providing this surgery at present. This includes many of the trusts longest waiters.	Regional		

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RECOMMENDATION 17					
Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Pathways for female and functional urological treatments need to be clearly agreed and described.	SPPG	Action to be discussed at the Regional Urology PIG meetings Feeds into Gynae GIRFT recommendations			

Received from the SHSCT on 11/06/2024. Annotated by the Urology Services Inquiry.

Outpatient Care					
RECOMMENDATION 18					
Original Findings	**Responsible Person**	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.		The Southern Trust are participating in the Regional Outpatient Modernisation Project. Mr Haynes has volunteered for the Enhanced Clinical Triage and Patient Initiated Follow up (PIFU) Task & Finish Groups. Meeting scheduled for Mon 15/1/24 (Led by SPPG) As per Southern Trust sharepoint Urology New : Review ratio at the end of Nov 23 is 1:5 average. This is not a true reflection as there are more review clinics than new clinics due to priority of MDM reviews. Assurance the Southern Trust consultants are following the appropriate follow up for the patient to maximise the efficiency of time i.e	Ongoing		

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		PIFU, discharge back to GP, virtual, enhance triage and scan first, use of nurse specialist Regional group is established to work through			

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c. Cancer pathways: 14 day for breast cancer, and 31 and 62 pathways for all other cancers;
d. The review backlog numbers and trends.

29.10 Actions by specialty were identified at a high level for more detailed planning after the meeting.

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

30.1 Virtually all meetings with urology staff regarding patient care and safety were scheduled meetings due to the need to identify a suitable time which did not impact on the consultants' clinical schedules. These meetings were scheduled with the urgency required and all are detailed in responses to other questions. The only two informal meetings that I can recall are detailed below.

30.2 These two meetings, which were not scheduled but which were required on an urgent basis, were as follows:

a. A meeting at my request of myself as Director, Mr Mackle as AMD and Mr O'Brien, Consultant urologist. The meeting took place at the end of a working day after Mr O'Brien had completed his main theatre list. I had been notified that day that Mr O'Brien had not been triaging his red flag referrals and was travelling to the BAUS Conference in Barcelona the following day. Mr Mackle and myself impressed on Mr O'Brien the requirement and importance of triaging red flag referrals. The permission to attend the conference the following day was refused unless the red flag referrals were triaged before travelling the following day. This resulted in the red flag referrals being triaged and Mr O'Brien travelled to the conference. I have no notes of this short discussion which took place in late April 2010. The red flag referrals continued to be

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

This could have been achieved if there was a medical lead to the Service Directorate.

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

71.1. No; they were not fit for purpose. By 2018, it was generally accepted by members of the Executive Team that the Trust internal governance arrangements needed review. It is self-evident that the governance arrangements did not appropriately identify and remedy the issues described in the MHPS report. I am aware that, at the time, I was leaving the Trust in 2018, Mr Devlin (Chief Executive) was about to conduct a review of governance arrangements, however, I have no knowledge of the outcome of that process.

71.2. In relation to reporting lines, see my earlier answers including those to Questions 67 and 70.

71.3. I believe that, in hindsight, I was too reliant on issues of concern being escalated to me from the directorates at their initiation. If I was in post again, I would put in place a system of proactively inspecting professional governance arrangements directorate by directorate to identify issues at an earlier stage.

71.4. I believe that, in my time as Medical Director, we managed to completely reform the team dynamics of the senior medical leadership team at AMD and Clinical Director level, building trust and confidence, however, much more needed to be done to embed a culture of trust.

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

In delivering these responsibilities, I am accountable for the Trust's performance to the Health and Social Care Board (HSCB) and DoH and report through agreed performance management arrangements established for the 2020-21 year including those actions put in place to respond to and subsequently to recover/rebuild from Covid-19 pandemic surge(s). The mechanisms I use to assure myself and Trust Board are below:

- Trust Governance Committee - Provides assurance to the Board on all aspects of the governance agenda (except financial control). This forum brings a range of clinical governance metrics and allows for dynamic triangulation and challenge and scrutiny to be offered by committee members
- Controls Assurance Standards – The Controls Assurance assists in the provision of evidence of the Trust performance to manage in meeting our objectives to protect patients, staff, public and other stakeholders against risks from all sources
- Trust Integrated Governance Framework 2017 - The framework sets out the arrangements for integrated governance within the Southern Health and Social Care Trust for the four year period 2017/18 to 2020/21. It is based on the extant integrated governance strategy 2007 to 2009 which was approved by Trust Board in February 2008 and covers all domains of governance associated with the delivery of health and social care services including corporate governance, clinical and social care governance, information governance, risk management, performance management and financial governance.
- Trust Governance Statement – As part of the Trust Annual Report the Governance Statement provides assurance that the Board exercises strategic control over the organisation through a system of corporate governance which includes:
    - Management Statement and Financial Memorandum;
    - Standing orders including powers reserved to the Board and powers delegated to its Committees and standing financial instructions
    - An Audit Committee;
    - A Governance Committee;
    - An Endowments and Gifts Committee;
    - A Remuneration Committee;
    - A Patient and Client Experience Committee; and
    - A Performance Committee.

The Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services. Committee structures are in place to reflect this integrated approach and to support the Trust Board. The following describes in more detail the role of the Trust Board, its Committee structure and attendance during the reporting period.

In 2019 I commissioned two reviews to provide assurances around clinical governance processes. Having worked in other Trusts I was concerned that the assurance processes were not as robust as I had been used to. In particular the importance of a completely integrated governance system was not as explicit and in my experience felt under resourced. Therefore I progressed with two reviews.

- Trust Board development workshop, 13 November 2019, which consisted of the following elements
    - Board contribution to the Trust's performance
    - Board culture of collaboration, co-production and learning
    - Strategy, Accountability and Culture and Corporate plan priorities
    - Continuing development and collectively leadership on the implementation of the Corporate plan

- 2019 HSC Leadership Centre - Review of Clinical and Social Care Governance (appendix 13) - Health and Social Care (HSC) Leadership Centre undertook an independent review of clinical and social care governance within the Trust, including

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governance arrangements within the Medical Directorate and the wider organisation. The output of this review was a series of recommendations for implementation by the Trust.

There were a total of 48 recommendations made which were broadly categorised under the following themes;

- Corporate Good Governance (Trust Board including Board Committees and Sub-Committees;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Governance Information Systems including Datix;
- Clinical and Social Care Good Governance Structures.

These recommendations became the basis of our Clinical and Social Care Governance (CSCG) change journey.

How do you ensure that the Board is appraised of both serious concerns as well of current performance against applicable standards of clinical care and safety?

As Chief Executive I ensure Trust Board is appraised of both serious concerns and current performance against applicable standards of clinical safety via the following mechanisms:

- Non-Executive Director briefings conducted by myself (monthly currently, previously were weekly during pandemic period)
- Trust Governance Committee - As above, Governance Committee also allows for issues of serious concerns / performance issues that are identified to be raised and discussed directly with Governance Committee members
- Trust Board Meetings – Trust Board meetings hold a 'confidential' session at the beginning of each meeting that is closed to the public allowing for sharing of information on concerns / performance issues that are identified to be raised and discussed directly with Trust Board members. These confidential meetings are minuted to ensure an accurate record but they are not held in public session so that issues of policy in development or confidential in terms of identifiable information can be shared

What is your view of the efficacy of these systems?

As reference above, in 2019, I commissioned the HSC Leadership Centre to review the complete governance system within the Trust. I was concerned that the system was disjointed and that from my experience the system was not operating as I had experienced in other HSC organisations. I had a number of concerns based on my experiences;

1. The level of expenditure on the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines.
2. There was little evidence of a systematic and dynamic flow of clinical and social care information to SMT on a regular basis. Clearly if there was an issue of concern there was evidence of items being raised. However my concern was that this was based on a 'push' system from the directorates, not from a regular systematic review process.
3. The level of data and statistical evidence being brought to the SMT, in respect of quality and safety, was lower that what I was used to in other organisations.

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	As can be seen in appendix 13 the author concluded "*The analysis demonstrated that many of the building blocks for good governance are in place e.g. a Board Assurance Framework, Corporate Risk Register, Risk Management Strategy and operational policies e.g. adverse incident reporting, health and safety management, claims and complaints management. However, gaps in controls and assurances in these systems and processes have been identified and recommendations made"* It is important to note, and as articulated in the minutes of the Trust Board Workshop 27/2/2020 (appendix 14), I perceived that the Trust Chair, Roberta Brownlee, was annoyed with the way I had commissioned and managed the review. She felt that as Chief Executive I did not have the right to commission such a report as the management of the non-executive functions were not within my gift. You can note from the minutes that I agreed that we would move forward with the actions relating to clinical and social care governance only. As a result of the clinical and social care governance review I secured investment in increasing both the resource assigned to and organisational profile of the Clinical and Social Care Governance (CSCG). In 2019 I approved (appendix 15) an additional £1/2 million spend on strengthening CSCG within the Trust. Major changes have been delivered in the management of SAIs, Complaints and Standards and Guidelines. Currently under my direction the Trust Medical Director is redesigning a sub-committee structure to bring together a greater range and deeper cut of CSCG information for consideration by SMT and Trust Governance Committee. (appendix 16)

Q12	**Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done? Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?**
Response	*Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done?* The Trust operates a performance committee which assists the Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines. The full terms of reference are provided below along with the Trust Performance Management framework which is part of the Board Assurance Framework and complements the Trust's Governance Arrangements. The Trust has recently invested in increased Business Intelligence solutions that support 'dashboard' dynamic performance indicators that will allow for corrective and interventional actions to be made in a timely manner. *Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?* As described in question four, in October 2019, we introduced a new performance committee

Function	Assists the Trust Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.
Membership	• Chaired by Non-Executive Director • Four Non-Executive Directors • In attendance: - Chief Executive - Executive Directors (Finance, Medical, Nursing & AHPs and Social Work – also Director of CYPS) - Director of Performance and Reform

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automatically placed on PAS lists depending on the GP grading of risk. On the face of it, this was a failsafe action to protect patients from being lost to follow-up.

71.14 In actual fact, what then happened was that the underlying problem was not addressed, namely the non-triage, and at the same time false assurance was given that because patients were on a list they were safe. In addition, this also served to mask who had been triaged and who hadn't and meant then that, when attempts were made to quantify the breadth and impact of the non – triage, these patients were very difficult to identify and revisit and their outcomes were potentially impacted upon as a result.

71.15 Another example of this appears to have been the limited development and ownership of CSCG processes in the Southern Trust prior to the Champion Review which then led to a system that was challenged in managing patient safety concerns in Urology and which for example had lost its functioning Clinical Audit functions and had at times rudimentary approaches to other CSCG approaches.

71.16 Moving to the specific limbs of Question 71, I address these in the table below.

	Response
Do you think, overall, the governance arrangements were fit for purpose?	I arrived in the Trust on the 1st December. The Acting Assistant Director for Governance Trudy Reid was appointed in January 2019, both of us then assuming key roles in relation to the Corporate aspects of Integrated Clinical and Social Care Governance (CSCG) at around the same time. I was completely new to the organisation and in the course of my induction and orientation was increasingly aware that some of the key functions that were required to assure governance supporting patient safety, were rudimentary. I was concerned whether some of these governance processes were fit for purpose.

	On the basis of this, I approached the Chief Executive and asked for support in commissioning a review of CSCG across the Trust. This was undertaken through the Leadership Centre by Mrs June Champion who is a highly regarded local expert in this area. She produced the Champion Report in September 2019.
Did you have concerns about the governance arrangements and did you raise those concerns with anyone?	Yes, I had concerns about the paucity of the functions usually associated with providing a robust system of governance. I brought this to the attention of the Chief Executive, Mr Shane Devlin, who supported the commissioning of Mrs June Champion to produce the Champion Report in September 2019. In addition to this, to strengthen governance assurance in the operational directorates I introduced and led the weekly Trustwide Governance Group which includes Clinical Executive Directors and Divisional Medical Directors, which reports weekly to SMT and monthly to Trust Non- executive Directors ATTACHMENTS: CHAMPION REPORT, RESPONSE, UPDATED ACTION PLAN. Documents located at S21 No 29 of 2022, *53. CHAMPION GOVERNANCE REVIEW 2019, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS* I also had concerns about Professional Governance in the ST and this was strengthened to address these concerns.
If yes, what were those concerns and with whom did you raise them and what, if	The concerns were that the Clinical and Social Governance systems, specifically management of complaints ,SAI, standards and guidelines, clinical audit and Datix, mortality reporting and the quality assurance of these systems and triangulation of these systems were not well enough developed to provide enough governance assurance. This was raised with Mr Devlin, SMT and Trust Board and plans and funding strategies were agreed through a programme of improvement. The first aspect of this was to develop plans for improving Standards and Guidelines, Datix and SAI in year one and mortality reporting was brought up to date. Through the relevant strategies these have been progressed following significant investment.

anything, was done?	The next phase, significantly delayed by the pandemic, has been the development of the Clinical Audit Strategy, which is currently underway (ATTACHED). Document located at *S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022* Thus, this is still a work in progress and is being developed as described in the Action Plans and in the improvements outlined in my answers to Questions 7, 8, and 21 in relation to Professional and Clinical Social Care Governance. I am also progressing the restructuring of how governance is assured by Trust Board across the Trust through restructuring of the operational directorates in order to assure quality and safety from bed to board, second and third line assurances are being developed through use of clinical audit, use of internal audit and the changes through the Champion Report and monitoring by external agencies. Governance training is being developed for delivery throughout the Trust to strengthen awareness of speaking up, governance processes, the importance of triangulation and quality assurance across the organisation and the importance of not viewing patient safety and clinical and social care governance in isolation. All of these have been developed in relation to the concerns that have been raised in the course of maintaining high professional standards in relation to Mr. O'Brien and in the course of the Serious Adverse Incidents chaired by Drs. Johnston and Hughes and throughout the course of the Look Back exercise and with the Public Inquiry. The Professional Governance concerns to which I have referred in my answer to Question 21 in relation to the process of Appraisal, Revalidation and leadership in particular were identified as requiring improvement as part of the review of professional and medical management processes which I undertook and have developed and am in the process of embedding.

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

72.1 No

Southern Health and Social Care Trust

Quality Care - for you, with you

REPORT SUMMARY SHEET

Meeting Date	Governance Committee 6th September 2018
Title	SHSCT Clinical Audit Strategy, June 2018
Lead Director	Dr Ahmed Khan, Medical Director (Interim)
Corporate Objective:	Safe, high quality care
Purpose:	To provide a strategy for delivering on clinical audit within the Southern Trust

Summary of key issues for SMT

Key issues

This paper describes:

- a strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit is being appropriately managed and delivered;
- the arrangements for presenting the Trust's consolidated annual clinical audit work programme to SMT for assurance and approval;
- the clinical audit reporting arrangements to SMT, Governance Committee and Trust Board.

Key issues / risks for discussion:

- Ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance
- Ensuring there is a sufficient number of staff in the corporate clinical audit team and operational directorates to support delivery of the approved clinical audit work programme.

Summary of SMT challenge/discussion:

- The Clinical Audit Strategy was approved, for onward referral to Governance Committee
- The strengthened interface between clinical audit and quality improvement was endorsed.
- Further work is required to review the resources to support clinical audit/M&M and QI.
- An extension was granted until 31 July 2018, to facilitate two Operational Directorates in compiling their clinical audit work programmes 2018/19.

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

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SHSCT Clinical Audit Strategy

June 2018

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

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Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Executive statement

The Southern Health & Social Care Trust is committed to delivering effective clinical audit in the clinical services it provides. The Trust sees clinical audit as a cornerstone of its arrangements for developing and maintaining high quality patient-centred care.

This strategy outlines the arrangements for defining, prioritising, approving, supporting, monitoring and reporting on the Trust's annual national, regional and local clinical audit work programme. The strategy also strengthens the assurance processes, as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy.

It is expected this one year clinical audit strategy, in line with the Trust's wider governance and assurance mechanisms, will inform and enhance the process of improving clinical services.

Dr A Khan
Medical Director (Interim)

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

1.0 Organisational context

Clinical audit forms an integral part of the clinical and social care governance framework through which NHS 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 clinical care will flourish.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit.

This strategy seeks to establish a common framework across the Trust to ensure clinical audit activity follows best practice guidance, and strengthens the assurance processes as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy. The value of audit projects is realised within the clinical assurance process and in terms of the improvements arising as result of clinical audit outcomes.

Effective national, regional and local clinical audit activities contribute to the delivery of the Trust's corporate objectives. It is important therefore that clinical audit is not seen as an isolated quality improvement activity, but as one of a set of tools which teams and services can use to improve the quality of care that is delivered to service users.

In developing an annual clinical audit work programme, it is essential to consider the links to wider quality and governance frameworks such as recommendations arising from serious adverse incidents, risk management processes, NICE standards and guidelines, etc.

HQIP advocates that if organisations are to gain the greatest benefit from clinical audit, certain pre-requisites must be in place (Appendix A).

2.0 Definition of clinical audit

For the purposes of this Strategy, HQIP's definition of clinical audit will be 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"*

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

3.0 Aims

The aims of this strategy are to:

- Use clinical audit as a process to embed and measure clinical quality at all levels within the Trust, demonstrating the benefits of audit through assurance, and highlighting areas for improvement in the quality of care and services to the patient/service user.

- Identify and develop a prioritised annual national, regional and clinical audit programme, which reflects organisational need.

- Ensure a consistent approach to prioritising, developing, monitoring and reporting on clinical audit activity throughout the Trust.

- Ensure effective and timely reporting on the outcomes of audit activity

- Incorporate the recommendations arising from the internal audit of clinical audit (Appendix B).

4.0 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.

5.0 Developing and prioritising operational directorate national, regional and local draft clinical audit work programmes

This strategy describes the processes of developing and prioritising the Trust's clinical audit programme which reflects key national, regional and local drivers for clinical audit ("top-down" requirements), balanced against directorate/division/service priorities and the interests of clinicians ("bottom-up" initiatives).

The first step in developing a comprehensive annual work programme is the identification of all the clinical audit projects which must be undertaken in order to meet external monitoring requirements. HQIP propose clinical audit programmes be categorised into 4 distinct elements, with "external must do" audits being assigned the highest priority as Level 1 projects.

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

The HQIP defined priority levels for clinical audits are as follows:

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Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

The Trust's paper, *National Clinical and Social Care Audits and Clinical Outcome Review Programmes*' endorsed by SMT on 2 March 2016, highlighted a list of national audits for 2016/17 approved *by NHS England Quality Accounts*. These projects are identified as Level 1 in the table above.

The *NHS England Quality Accounts* List of national audits will be circulated annually to operational directors, Associate Medical Directors and Assistant Directors for identification of audits relevant to their areas of responsibility and inclusion in the directorate's "Level 1" annual clinical audit work programme.

HQIP propose internal 'must-do' clinical audits, which emanate from governance issues or high profile local initiatives, be classified as Level 2 audits.

When the 'must-do' Levels 1 and 2 audits have been identified, directorates should, where appropriate, propose projects they believe would be of benefit to patients, service users, clinicians and managers. These audits should be classified as Level 3 and Level 4 audits, as determined by the operational directorates.

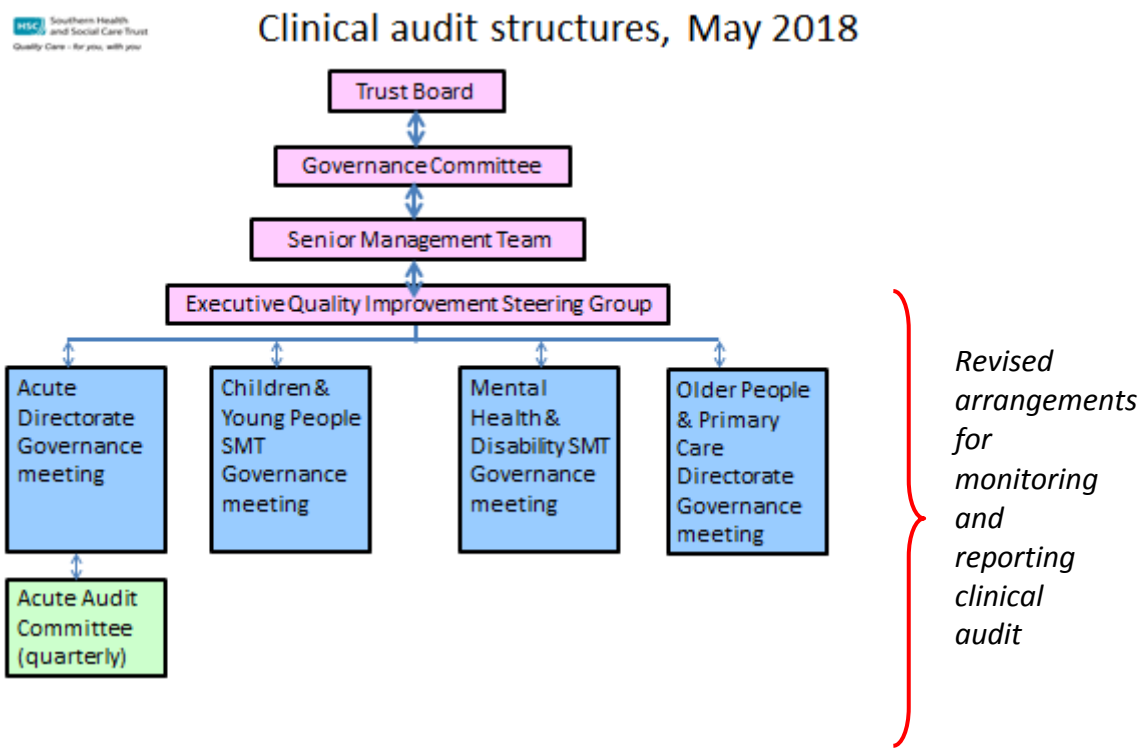
Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Taking the 4 levels of audit into consideration as appropriate, operational directorate's should agree their draft clinical audit work programme within the operational structures outlined in 6.0 below, The work programme should be forwarded to [redacted] for collation in the Trust's draft annual clinical audit work programme, which the Medical Director will take forward for review and approval. The draft clinical audit work programme 2018/19 is outlined in Appendices D and E below.

The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures.

6.0 Approval of the annual clinical audit work programme

The Medical Director will present the Trust's draft annual clinical audit work programme to Executive Quality Improvement Steering Group / SMT for review and approval. Following approval, the work programme will be forwarded to Governance Committee and Trust Board for information.



7.0 Additions to the annual clinical audit work programme

On occasion new audits may be identified throughout the year. Compiling and prioritising the annual clinical audit work programme should not stifle projects that emerge during the year that will contribute to improvements in care.

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Some of these projects might be new 'must-do' audits which could not be determined when the work programme was being developed, while others may represent innovative ideas from clinicians which are as valid and important as ideas proposed when the programme was originally developed. Existing quality improvement work may also identify emerging work areas for clinical audit

New projects identified within year will be highlighted to the Executive Quality Improvement Steering Group / SMT by Operational Directors.

These audits should also be highlighted to [redacted] for registration on the Trust's centralised clinical audit database.

8.0 Registration of clinical audits

All clinical audit projects must be notified to [redacted], for recording on the Trust's centralised clinical audit database.

9.0 Monitoring and reporting schedule

Audit findings and recommendations should be discussed within the appropriate operational directorate structures.

For corporate reporting purposes, a standardised reporting template to assist directorates in summarising the audit findings and areas for improvement, for inclusion in the 6 monthly audit assurance report to Senior Management Team, is outlined in Appendix C. These audit summaries should be approved within operational directorate structures and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.

The reporting schedule is outlined below:

Audit activity should be included as a standing agenda item within the appropriate **sub-committee structures** as determined by each operational directorate	Monthly
Monitoring of national, regional and local clinical audit should be discussed within the appropriate **operational directorate** structures (Table 6.0 above)	Quarterly as a minimum
The Trust's Audit Assurance Report should be presented to the Executive Quality Improvement Steering Group, and following approval will be forwarded to the Senior Management Team, Governance Committee and Trust Board for information.	6 monthly

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

10.0 Quality assurance processes for data submission to external host organisations

The nominated Consultant Audit Lead/Supervisor will ensure data being submitted to an external host organisation is in keeping with Data Protection Act, Caldicott Guidance and the Trust's Information Governance protocols.

He/she will liaise with the relevant Associate Medical Director, Assistant Director and Operational Director to approve data prior to submission to an external host organisation and will be supported in this role by the Clinical Audit Facilitators, as required.

11.0 Resources to support the clinical audit work programme

The current staffing level in the corporate clinical audit and M&M team and operational directorates is insufficient to support and deliver the draft clinical audit work programme, 2018/19.

There may be potential to consider the resource requirements jointly with admin support for M&M, in light of the Hyponatraemia Inquiry recommendations, as M&M and clinical audit are intrinsically linked.

12.0 Review arrangements

This strategy will be reviewed in 1 year's time.

June 2018

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

SHSCT Clinical Audit Strategy

Action Plan, February 2018 (updated June 2018)

	Proposed action	Lead	Timescale
1	Directorates should ensure clinical audit structures exist to support the promotion, development, monitoring, reporting and quality assurance of clinical audit activity at operational level	Operational Directors	March 2018
2	The NHS England Quality Accounts List of national audits should be forwarded to operational directorates in February, for their review in developing a draft annual clinical audit work programme	Head of Service, clinical audit	Feb 2018
3	Operational directorates should develop and deliver their annual clinical audit work programme, in line with the prioritization criteria in the clinical audit strategy.	Operational Directors, AMDs & Assistant Directors, in consultation with service teams	March 2018 – extended to 31 July 2018
4	The Medical Director will present the Trust's consolidated annual clinical audit work programme to the Executive Quality Improvement Steering Group / SMT for assurance and approval	Medical Director	April 2018 –extended to 31 July 2018
5	The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures	Operational Directors, AMDs & ADs	Sept 2018
6	Clinical audit projects agreed within year should be highlighted to the Executive Quality Improvement Steering Group / SMT, and registered [redacted]	Operational Directors	prn
7	Following corporate approval, the clinical audit strategy should be launched within operational directorates	Head of Service, clinical audit	asap after approval
8	Operational Directorates should encourage the registration of all approved clinical audit activity. Details of audits to be registered on the Trust's centralised audit database should be forwarded to [redacted]	operational directorate "approval arrangements"	Ongoing
9	**Operational level:** Audit findings should be discussed within the appropriate operational directorate structures. **Corporate reporting:** Completed audit templates (Appendix C) should be approved within operational directorate arrangements and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.	Clinical Audit Leads Audit Committee arrangements at operational level	Ongoing 6 monthly

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

10	The Medical Director will present the 6 monthly audit report to the Executive Quality Improvement Steering Group / SMT, and following approval submit to Governance Committee and Trust Board for information.	Medical Director	May, Nov. May 2018 report - extension to 31 July2018
11	Clinical audit presentation to Governance Committee, including progress on outstanding recommendations from the Internal Audit of clinical audit	Head of Service, AD, Medical Director's team	Autumn 2018
12	Consider the potential to review clinical audit and M&M resources in light of the Hyponatraemia Inquiry recommendations and the interface between M&M and clinical audit	Medical Director	tba

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

HQIP Clinical audit best practice criteria		Appendix A
	Theme	**Reference source**
1.	Clinical audit is a quality improvement activity and therefore it functions best as part of a planned programme of quality improvement that has been approved by the Board and/or senior management of the organisation.	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
2.	The Board should have dedicated time set aside to review both the clinical audit programme and the outcomes of individual projects	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
3	An effective clinical audit programme will cover the requirements and needs of a number of stakeholders including the Board, clinicians, service users and commissioning bodies. The programme should be developed in accordance with clear policy and agreed following consultation with clinicians, managers and patient representatives. The programme should be closely monitored and progress reported regularly at Board and service delivery level. An annual report, linked where appropriate to the Trust quality account, should be presented to both the Board and patient groups for scrutiny before publication.	HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/N{PCA/2016-007
4	Service user and public involvement in clinical audit should be embedded in the organisation's Personal & Public Involvement (PPI) strategy. The clinical audit programme should include patient-focused projects, and the roles played by service users and lay representatives should be acknowledged in clinical audit reporting at all levels.	HQIP, Patient and Public Involvement (PPI) Strategy: www.hqip.org.uk/BPCA2016-003 HQIP,Patient and Public Invovement in Quality Improvement: www.hqip.org.uk/BPCA/2016-004 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005 HQIP, Introductin to quality improvement for pateints and public: www.hqip.org.uk/BPCA2016-006

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5	In deciding which clinical audits should be undertaken, the following factors should be considered: Clinical priorities, including clinical risks, adverse incidents and patient safety Organisational priorities, including service redesign and development Patient and service user prioritiesCommissioner priorities and specifications, including Commissioning for Quality and Innovation Frameworks (CQUINs) and NHS Standard Contract requirements The outputs from the national Clinical Auidt and Patient Outcomes Programme (NCAPOP) and other national clinical audits Professional revalidation, appraisal and training needs	HQIP, Developing a clinical audit programme: www. Hqip.org.uk/BPCA2016-007 Using clinical audit in commissioning: www.hqip.org.uk/BPCA2016-008 HQIP, Srtatutory and mandatory requirements for clinical audit: www.hqip.org.uk/BPCA2016-009 HQIP, Guide to involving junior doctors in clinical audit: http://www.hqip.org.uk/rsources/involving -junio-doctors-in-clinical-audit/ GMC, Guidance on revalidation: http://www.gmc-uk.org/doctors/revalidatin.asp
6	Clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate.	HQIP, Guide to quality improvement methods: www.hqip.org.uk/BPCA2016-010
7	Organisations must have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. The findings from clinical auidts may be used as part of the Board Assurance Framework, but full assurance can only be obtained if the quality improvement aims of the project have been achieved. Governance plans should include arrangements for participation in local and regional cross-organisational audits	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001 HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007
8	Policies and procedures must be in place to ensure that clinical audit (and all other quality improvement activities) are undertaken in a way that complies fully with current information governance legislation and guidance, and in consultation with local information governance leads and Caldicott guardians	HQIP, Information governance for local quality improvement: www.hqip.org.uk/BPCA2016-011

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

9	All staff within an organisation should be made aware of, and comply with, the governance arrangements in place, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits	HQIP, Clinical audit policy and stratgegy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA2016-012
10	The organisation must enable the conduct of good quality clinical audit by providing appropriate resources to support the process. This includes dedicated time for audit and an appropriate level of funding. Organisations should have in place: A senior clinician able to lead on clinical audit across the whole organisation Clinical leads for quality improvement at service delivery level Clinical audit practitioners who can manage the audit programme and support the process A programme for supporting doctors in training to ensure that the clinical audit and quality improvement activities they undertake as part of their training to deliver benefits to the organisation.	HQIP, Developing a clinical audit programme: ww.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA/2016-012 HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014
11	The organisation should seek to improve the knowledge and skills of all staff in quality improvement. Training in clinical audit should be available for all staff and where appropriate for lay representatives. All staff should be encouraged to participate in clinical and other networks that provide knowledge sharing and opportunities for staff development	A promise to learn – a commitment to act: improving the safety of pateitns in England (the Berwick report): htpps:/www.gov.uk/government/publications/Berwick-review-into-patient-safety HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Internal Audit recommendations on Clinical Audit (as at Feb 2018)	Appendix B

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18
CC CLINICAL AUDIT (15/16/16)

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.1 INTEGRATED GOVERNANCE STRATEGY				
1	1	As previously recommended in both the Board Effectiveness Audit 2015-16 and the Clinical and Social Care Governance Audit 2015-16, the Integrated Governance Strategy should be updated, approved and re-issued. The Strategy should accurately reflect the current committee structure within the Trust and the current reporting arrangements and requirements. **Responsible Officer:** Assistant Director Clinical & Social Care Governance (ADCSCG) **Original Implementation date:** June 2016	**Duplicate recommendation** refer to D – above - Governance Including Board Effectiveness This recommendation has not been counted in the results table above.	
1.2 CLINICAL AUDIT STRATEGY				
1	1	The Trust should develop a comprehensive Clinical Audit Strategy. The Strategy should accurately reflect the committee structure across the Trust and the reporting arrangements. It should also include a combination of national, regional and local priorities with sufficient resources identified to facilitate completion of the programme. **Responsible Officer: Head of Audit/ Assistant Director CSCG** **Original Implementation Date: 1st July 2017**	**NOT IMPLEMENTED** The Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1.3 COMMITTEE STRUCTURES FOR CLINICAL AUDIT				
1	2	The Terms of Reference for the Acute Audit Committee should be approved and the committee reinstated if appropriate. **Responsible Officer: Director of Acute Services** **Original Implementation Date: 1st September 2017**	**NOT IMPLEMENTED** All structures presently in place will be reviewed.	**Revised Implementation Date:** 1st September 2018

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SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.4 GOVERNANCE ARRANGEMENTS AT CORPORATE LEVEL				
1	2	Management should strengthen the governance and oversight arrangements in respect of clinical audit activity. This should include the following: • An annual overarching corporate clinical audit programme, to be approved by the Governance Committee. • Regular reports covering all clinical audit should be submitted regularly to the SMT and Governance Committees to monitor progress against the programme. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As noted above, the Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1	2	The CSCG team should put in place a corporate process for sharing outcomes and monitoring areas of clinical improvement, to ensure that the outcome of all audits including local audits are shared with the appropriate staff. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018
1	2	Governance / Audit leads within Directorates complete the registration process for recording the rationale for participation in the national audits and for prioritising directorate led audits against corporate targets. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.5 DIRECTORATE LEVEL				
1	2	Directorate audit plans should be developed annually for approval at Directorate Governance Committee. These should then be submitted for approval at SMT Governance Committee. This information should be shared with the corporate CSCG team. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Divisional audit plans should be developed annually for approval at Directorate Clinical Governance Committee. Subsequently regular reporting on progress against plans and major findings should be reported. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Regular reports should be produced and provided to the CSCG Corporate Team by each directorate detailing progress against approved directorate plans and major findings from audits completed. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

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SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
2.1 WRITTEN STANDARD OPERATING PROCEDURES (SOP) FOR CLINICAL AUDIT				
2	2	The Trust should ensure that written procedures for all aspects of the clinical audit are reviewed, updated and issued to all relevant staff as soon as possible. These should reflect current practice and link to a Clinical Audit strategy. **Responsible Officer: Assistant Director CSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.2 DATABASE OF CLINICAL AUDITS				
2	3	There should be a central database maintained with the details of all ongoing clinical audits within the Trust, whether local, regional or national. Each directorate should have access to the relevant section within the database to allow it to be kept up to date. **Responsible Officer: Assistant Director CSCG** **Original Implementation :1st September 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.3 TRAINING FOR CLINICAL AUDIT				
2	2	Training for clinical audit should be considered by management. The training needs should be assessed and an appropriate training programme developed. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: Implemented**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Standardised reporting template for inclusion in 6 monthly audit assurance report **Appendix C**

Audit assurance report template for completion by the clinical audit lead

Audit title	
Audit type	e.g. national, regional or Trust
Host organisation	
Audit lead	
Contact details	@southerntrust.hscni.net
Time period	Continuous Snapshot (please specify dates)
Directorate	
Division / speciality	
Report accessed via	

1.0 The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.

Please include compliance against the national / regional compliance, where available

		SHSCT compliance	National or regional compliance
1.			
2.			
3.			

2.0 If appropriate, areas for improvement, actions taken and status

National, regional, Trust recommendations		
Recommendation	**Action taken**	**SHSCT status as at date**
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced

Please continue overleaf as required.

NB where an existing audit template is available e.g. NCEPOD, please submit this instead of completing section 2.0 above

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

9.0 RECOMMENDATIONS AND ACTION PLANNING

defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.

Timescale – Immediate and ongoing

Assurance - 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.

Recommendation 9.

The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.

Timescale - 3 months

Recommendation 10.

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

Recommendation 11

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.

References:

1. Hoffmann, R., et al. Innovations in health care and mortality trends from five cancers in seven European countries between 1970 and 2005. Int J Public Health, 2014. 59: 341.

2. Oliver, R.T., et al. Radiotherapy versus single-dose carboplatin in adjuvant treatment of stage I seminoma: a randomised trial. Lancet, 2005. 366: 293.

3. Laguna M.P., et al EAU Guidelines: testicular cancer. https://uroweb.org/guideline/testicular-cancer/note_127-129 (accessed 26/02/2021)

4. Peer review Self-Assessment report for NICaN 2017

5. Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016)

6. EAU guidelines for penile cancer: section 6.2.1 (2019)

7. NICE improving outcomes in urological cancer (2002)

8. NICAN Urology Cancer Clinical Guidelines (March 2016), Penile Cancer treatment Section 9.3 (3).

Received from Dr Dermot Hughes on 08/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Reference No: 73512039

JOB DESCRIPTION

JOB TITLE: Head of Cancer Services

BAND: 8b

INITIAL LOCATION: Craigavon Area Hospital

DIRECTORATE: Acute Services

REPORTS TO: Assistant Director of Cancer & Clinical Services

Job Summary

- To be responsible for the operational / performance management and strategic development of Cancer services to include Chemotherapy Services.
- To be responsible for the cancer tracking of patients through the cancer pathways
- To be responsible for leadership, service provision and service development of Cancer services and ensuring high quality patient centred services.
- To be responsible for the operational Line Management of the Clinical Nurse Specialists and Palliative Care Nurses working within Acute Services
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and guidelines
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a cancer service strategy, which support the Trust's and Division's overall strategic cancer direction and ensures the provision of a high quality responsive service to patients within resources.

As a Head of Service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY RESULT AREAS

1. Quality & Governance

Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

Be committed to supporting honest, open communication and effective multi-disciplinary working.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

Support the Assistant Director with the implementation of quality initiatives such as Investors in People and PPI Initiatives.

2. Leading & People Management

Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.

Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.

Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

Ensure the division implements and adheres to Trust HR policies and procedures.

Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Performance Management

Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

Support the Assistant Director in achieving key access and performance targets applicable to the service area through robust planning, service improvement and collaboration through Acute Services

Make sure that services are delivered to the standard and quality expected by the HSCB – PHA, DHSSPS and Trust Board.

Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

Identify and contribute to local, regional and national development initiatives e.g. clinical networks and national programmes.

Make sure that all recommendations arising from RQIA/External bodies inspections e.g. Cancer Peer Review/NEPOD and are implemented in a timely manner.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Act as a member of the division's senior management team and contribute to its policy development processes.

Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

Assist with the development of the strategic cancer plan including the introduction of new cancer therapies, for the delivery of operational cancer services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSCB - PHA priorities.

Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic cancer planning initiatives and targets e.g. Cancer Standard Framework Document

Work with members of relevant teams on the innovative development of new and existing services e.g. the implementation of the Acute Oncology Model

5. Operational Management of Clinical Nurse Specialists and Palliative Care Nurses

As Line Manager of the above nurses ensure that systems and processes are in place that enables safe, appropriate input to patient care across Acute Services.

As Line Manager ensure that the above nurses in the service receives appropriate training and on-going development to enable them to competently and safely fulfil their roles.

As Line Manager ensure that the above nurses in the service receive annual appraisals and clinical supervision programmes are in place with regular evaluation processes to support them.

Promote a culture of lifelong learning within these teams of nurses and to contribute to the standardisation of cancer nursing within the region.

To responsible for the delivery of cancer research within the Trust working closely with the AMD for R&D.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

6. Financial & Resource Management

Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

Participate in contract and service level negotiations with commissioners.

Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

Update and monitor the operational policies of the Division and take account of risk management needs.

Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

Ensure that environmental standards are appropriate for safe & clean care delivery.

7. Information Management

Ensure the effective implementation of all Trust information management policies and procedures within the Division.

Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

8. Corporate & Divisional Responsibilities

Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Cancer & Clinical Services.

Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.

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Southern Health and Social Care Trust

Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

Participate in and comply with requirements in the production of performance reports.

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

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

9. General Management Responsibilities

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

Ensure that the review of performance identified above is performed for all levels of staff within your remit of responsibility in accordance with the Trust policy.

Maintain good staff relationships and morale amongst the staff reporting to you.

Ensure that the opportunities for talent to be developed are provided to ensure the service continues to develop.

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

Delegate appropriate responsibility and authority to the level of staff within your control consistent with effective decision making whilst retaining responsibility and accountability for results.

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

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

Promote the Trust's policy on equality of opportunity through your own actions and ensure that this policy is adhered to by staff for whom you are responsible.

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Southern Health and Social Care Trust

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

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

9. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

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Southern Health and Social Care Trust

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

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

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

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Southern Health and Social Care Trust

Quality Care - for you, with you

TITLE:	Associate Medical Director
DIRECTORATE/ DIVISION:	Acute Services – Cancer & Clinical Services
REPORTS OPERATIONALLY TO:	Director of Acute Services
REPORTS PROFESSIONALLY TO:	Medical Director
ACCOUNTABLE TO:	Chief Executive
COMMITMENT:	Maximum of 3 PAs - to be agreed with Director
LOCATION:	Craigavon Area Hospital / Daisy Hill Hospital

JOB SUMMARY

The Associate Medical Director (AMD) will, as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient.

Specifically, the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director / Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director Of Acute Services with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

KEY RESPONSIBILITIES

1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors of Acute Services to provide effective leadership within the Directorate**.**

The AMD Cancer & Clinical Services will work closely with the AMD's MUSC, SEC and ATICs to ensure effective clinical interfaces and patient pathways for out of hospital

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care, ambulatory care and admission for inpatient care are in place, reviewed and actioned.
The AMD Cancer & Clinical Services will work regionally on behalf of the Trust in the development of quality and safety standards for the service and will hold responsibility in the Trust for clinical leadership of these standards.

He / she will also contribute to effective service delivery within the department by managing implementation of the following policies;

Appraisal

- Co-ordinate the approved appraisal system, ensuring a process is in place and operating within guidelines.
- Ensure necessary training (within the agreed budget) is available for medical staff (non-training grades) within the Directorate / Sub Directorate, manage the approvals process for same and oversee the Division's utilization of the budget for medical training and development.
- Monitor the implementation of appraisal within recommended timescales.
- Undertake appraisal for Clinical Directors.
- Prepare an annual Directorate / Sub Directorate Appraisal report for the Director of Acute Services to submit to the Medical Director (in relation to required Annual Trust Board Report).

Job Planning

- Provide leadership and support for Job planning within the Division for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors and Lead Clinicians and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Division / Directorate's service capacity needs and Service and Budget Agreement with our Commissioner

Implementation of HR policies for Medical Staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support

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Education and Training

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands).
- Provide leadership in implementing and achieving compliance with the European Working Time Directive.

2. CLINICAL GOVERNANCE RESPONSIBILITES

The AMD in conjunction with the Assistant Directors and Director of Acute Services will be responsible for having systems and processes in place to review and manage remedial action emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The AMD will have responsibility for the specialty M&M meetings and to ensure emergency medicine contributes to other specialty M&M meetings.

The AMD will be directly responsible to the Director of Acute Services for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements.
- Work with the Trust / Directorate Governance Co-Ordinator to ensure effective governance of services.

Standards

- Provide advice to the Director of Acute Services and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc.
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice.
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director.
- Assist in the preparation for external inspections.

Public Health and urgent operational issues

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- Provide advice to Director of Acute Services, Medical Director and colleagues (e.g. swine flu, HCAIs).
- Contribute as appropriate to the development and implementation of contingency plans and lead the implementation of these plans in relation to the medical workforce.

3. CORPORATE RESPONSIBILITIES

As a senior medical leader within the Trust the AMD will participate and contribute to the corporate performance of the Trust. He / she will share responsibility with other senior managers in the Trust for Trust activities and for the overall performance, clinical and service strategy.

The AMD will also be required to:

- Attend meetings of the Directorate Management team and / or regular meetings with the Director of Acute Services.
- Contribute to the Business Plan of the Directorate to help achieve Trust Delivery Plan priorities.
- Monitor activity against the plan and determine / advise on required actions in conjunction with Director / Assistant Directors of Acute Services.
- Lead the implementation of such plans as they apply to the medical workforce and / or clinical practice.

OTHER CORPORATE RESPONSIBILITIES

Service Development & Improvement:

- Maximise the effectiveness and efficiency of the services within the Division across the Trust's hospital network.
- Regularly review key service data in conjunction with Director / Assistant Director / Heads of Service and advise on delivery options.
- Provide a medical perspective on protocols / pathways related to service improvements.
- Provide input to decisions on the medical capacity required for service developments.
- Provide clinical leadership on service reconfiguration within the Division and Directorate.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's specialty collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

Communication

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

- Facilitate good communication with medical staff, (through planned meetings with consultant staff and other opportunities).
- Provide effective communication with other clinical and non-clinical managers in support of good multidisciplinary team working.
- Actively promote the development of clinical and professional networks across the Trust's hospital network.
- Actively participate in the AMD Forum which is led by the Medical Director.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

- Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which appointee will work.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

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

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SOUTHERN HEALTH AND SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE: Associate Medical Director – Cancer & Clinical Services

DIRECTORATE Acute Services

Notes to applicants:

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

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

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

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with licence to practice and specialist accreditation (CCT)

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

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IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Associate Medical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Laura White on 028 3756 0117.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

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Southern Health and Social Care Trust

Quality Care - for you, with you

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Clinical Director – Cancer Services

BASE: Southern Health & Social Care Trust Area

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Services

OPERATIONALLY RESPONSIBLE TO: Associate Medical Director – Cancer & Clinical Care

ACCOUNTABLE TO: Chief Executive

HOURS: Salaried Part-time position

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of Cancer Services across the Trust.

He/She will:

- Participate as a member of the Cancer & Clinical Care Divisional Team;
- Be responsible for medical operational issues within Cancer services the Trust;
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues relating to Cancer services
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES

Setting Direction:

- To support the Trust in the development of a high quality, responsive services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures within Cancer services
- Provide leadership and direction to consultants and other medical staff within the specialty.

Received from SHSCT on 28/09/2022. Annotated by the Urology Services Inquiry.

Service Delivery:

- To function as a member of the Divisional management team with responsibility for medical operational and professional issues within Cancer services.
- Work with the Associate Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the Division.
- Work with the Divisional Team to use the resources of the Division to deliver, in both quality and quantity, the activity and targets agreed for the Division.
- Work with the Divisional team to deliver efficient, effective services within the agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.
- Work with the Divisional Team in supporting the modernisation of related services.
- To support the Trust in planning a response to major incidents and outbreaks.

Quality, Communication and information management

- Provide clinical leadership to ensure the implementation of patient safety initiatives.
- Support the Associate Medical Director to ensure a programme of multi-professional clinical audit is implemented within the Division that supports the Southern Trust integrated governance strategy and support the development of benchmarking activities within the Division.
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the specialty.

Professional Leadership

- Support the Associate Medical Director to ensure the highest standards of clinical effectiveness and medical practice in the Division, including the consideration / implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- To place Patient Safety at the centre of specialty activity

Medical Education and Research

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the specialty, ensuring the appropriate Governance arrangements are in place

Received from SHSCT on 28/09/2022. Annotated by the Urology Services Inquiry.

Leading the Medical Team

- Support the Associate Medical Director in the implementation of the consultant contract within the specialty, ensuring the contract supports modernisation, quality improvement and achievement of access targets.
- Support the Associate Medical Director in the effective implementation and monitoring of modernising medical careers (MMC) and EWTD for junior doctors.
- Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Where required, take part in the recruitment process for new doctors or ensure that other colleagues do so effectively.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- Work with the Associate Medical Director to ensure a system of induction is in place for all doctors within the specialty.
- Work with the Associate Medical Director to develop and lead a team of Specialty/Site Leads to assist the Trust in the redesign, modernisation and improvement of service delivery.
- Support the Associate Medical Director in the appraisal of all grades of designated doctors, including locum tenens, in line with regional guidance.
- Ensure that doctors within the specialty comply with arrangements for the assessment of fitness for clinical work.
- Work with the Associate Medical Director and Assistant Director of Cancer & Clinical Care to ensure the equitable and fair management of annual, discretionary and study leave process which meets the needs of the service and the development needs of the medical workforce within the Trust.

Collaborative Working

- Actively promote the development of clinical and professional networks between the Trust hospital sites.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated.
- Support the development of effective multi-professional team working and communication across both acute hospital sites

General Responsibilities

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

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

Received from SHSCT on 28/09/2022. Annotated by the Urology Services Inquiry.

- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

Responsibility Allowance

- Responsibility Allowance: **£7,600 per annum** (This is a pensionable allowance)

- Dedicated time within job plans between **0.25 PA and up to a maximum of 1 PA per week.** This time allocation will be timetabled into the job plan as additional HPSS responsibilities and will be proportionate to the demands of the role, size of the division etc.

- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

Received from SHSCT on 28/09/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director –Cancer and Clinical Services (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services (Under Review)

RESPONSIBLE TO: Director of Acute Care (Under Review)

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

- To medically lead on all aspects of patient safety.
- To provide robust clinical leadership in reviewing and improving cancer and clinical services in the context of the Urology Public Inquiry.
- To lead on all aspects of medical professional and clinical and social care governance including:

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

Specific Divisional Responsibilities

- Provide oversight and development of a workforce strategy for the division that meets the needs of the changing health and social care landscape

- Promote, develop and strengthen effective multi-professional team working and assurance mechanisms to strengthen governance arrangements surrounding Cancer MDT processes

- Provide leadership and guidance regarding the development of Radiology, Pathology and Cancer services within the Trust

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and

staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals

annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

- IT Security Policy and Code of Conduct

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

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

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

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

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

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

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

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – Cancer Services

DIRECTORATE: Acute Services Directorate – Cancer & Clinical Services Division

RESPONSIBLE TO: Divisional Medical Director Cancer & Clinical Services Division

ACCOUNTABLE TO: Medical Director

COMMITMENT: 2PAs

LOCATION: Trust wide

Context:

The Clinical Director (CD) on behalf of the Divisional Medical Director (Div MD) will be a leader in Divisional Management Team and member of the Directorate Senior Management Team. The CD will report to the Div MD and will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The CD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviors. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The CD will have delegated responsibility on behalf of the Div MD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the Div MD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

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Specialties / Areas Responsible For

- Southern Trust Acute Oncology Services
- Southern Trust Palliative Care Services
- Mandeville Unit

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

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

Specific Divisional Responsibilities

- Contribute to strategy development for Cancer Services in the Southern Trust as part of the Divisional Senior Management Team
- To advise the Management Team of Divisional priorities and pressures within Cancer Services
- Provide leadership and direction to consultants and other medical staff within Cancer Services
- To function as a member of the Divisional management team with responsibility for the delivery of Cancer services across the Trust
- Work with the Divisional Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of Cancer MDT's
- Work with the Cancer & Clinical Services Divisional Team in supporting the modernisation of Cancer services.

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of

continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.

- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
    (a) delivery of safe, high quality and effective person-centered care
    (b) secures activity and performance
    (c) maintains ongoing financial viability
    (d) is aligned to corporate goals
- The Clinical Director will work with the Divisional Medical Director and the Assistant Director and professional leads, in partnership, to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

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Appraisal and Revalidation
To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of CD allocation.

Job Planning
- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Consultants and any other relevant medical staff.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff
- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management
- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the

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Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

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

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Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Young, Michael <[redacted]>
Sent: 16 November 2017 17:55
To: Carroll, Ronan
Cc: Corrigan, Martina
Subject: saline TURP issue

Dear Ronan
I write with regards to the saline TURP issue.
As you are aware the DoH had undertaken a review of irrigation fluid used for TURP surgery a few years ago after a significant adverse event in which a young lady died. As a result a clearly documented pathway noted that hospitals in Northern Ireland should move to using saline as opposed to glycine for irrigation. In the Southern Trust we have been using glycine and therefore it has been necessary for us to convert over to new equipment for our Consultants and team to be compatible with DoH guidelines.

Several saline resectoscope systems are available. We have proceeded through a process of trialling each of these. We have considered several factors, including efficiency of use through to the financial impact, before coming to a conclusion. We as a department felt this was important to undertake as there would be long term implication to our decision. In saying all of this, we still felt that a defined date to transfer over to the new system was needed. We defined this date as 1st January 2018. This date was defined as fitting a timeline that allowed for the trail period, quotes to be received, assessment and providing the Trust a reasonable period of time to purchase the equipment.

The move to using Saline for TURP resection has been dictated by the DoH. The consequences of not moving to its use will leave Consultant Urologists at risk as if another significant adverse incident occurs they will feel very much exposed. I am not sure the Southern Trust would be able to cover them properly if such an event occurred when it is clear the DoH had made their stipulation.

We were under the distinct impression that having gone through our selection process and giving adequate notice, as discussed at the Theatre Users group, that this date was reasonable and would be compliant with the DoH documentation and hence for the Trust to be able to report back to DoH on the same.

It has now come to my attention that the Trust is not able to or in a position to proceed with the purchase of this equipment. It is not clear why this is the case as we have been instructed to move over to this system by the Trust itself.

Urologists in the department will be maintaining their position for a switch to using saline to perform TURP as of 1st January 2018. If the new equipment is not available the Urologists will cease the current type of TURP surgery. I am sorry this appears a little dogmatic, but the DoH and Coroners case that has sparked this course has been clearly set out and leave Consultants vulnerable if they do not attempt to comply.

M Young
Lead Clinician Urology

Received from Michael Young on 01/11/2023. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 30 March 2016 16:17
To: Young, Michael; Corrigan, Martina
Cc: Glackin, Anthony; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP
Subject: Bipolar Resection

Michael and Martina,

I wish to take the opportunity to update you on my experience of trying bipolar resection systems.
I have tried the models on trial to date, and did so having disabused myself of any prejudice against their use.
As reported previously, I found their performance inferior to monopolar mainly as a consequence of the intermittency of the current, the lack of any small vessel fulguration whilst cutting and the much reduced rate of continuous irrigation.
I last use bipolar two weeks ago to resect the moderately enlarged prostate gland of an elderly patient.
I had to abandon bipolar resection after 10 minutes because of bleeding, poor irrigation and visualisation.
The intraoperative comparison of both systems was remarkable.
Bipolar resection placed this patient in intraoperative danger, and salvaged by monopolar resection.

I have therefore pledged not to do so again.
I will not use or try bipolar resection again,

Aidan.

Received from SHSCT 18/09/2023. Annotated by the UrologyServices Inquiry.

HSC Business Services Organisation

Southern Health & Social Care Trust

Review of Mr A's Compliance with Relevant Authorities/Guidance in terms of his Private Work 2020/21

nqa ISO 9001 Registered Quality Management

Received from Dr Maria O'Kane on 01/04/22. Annotated by the Urology Services Inquiry.

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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health and Social Care Trust for their assistance and co-operation during the course of the assignment.

Control Log

Working Draft Issued to Inform Exit Meeting:	28 April 2021
Exit Meeting Held On:	29 April 2021
First Draft Issued On:	30 April 2021
Management Actions Received:	13 July 2021
Final Report Issued On:	31 August 2021

Distribution List

Shane Devlin	Chief Executive
Helen O'Neill	Director of Finance, Procurement & Estates
Dr Maria O'Kane	Medical Director
Melanie McClements	Director of Acute Services
Heather Trouton	Director of Nursing

Received from Dr Maria O'Kane on 01/04/22. Annotated by the Urology Services Inquiry.

Introduction

In November 2020, at the request of the Urology Assurance Group, the SHSCT Chief Executive requested a review of Mr A's patients transferring into SHSCT as HSC patients. In addition, the review will consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Terms of Reference

The audit focused primarily on Mr A's change of status private patient's work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of SHSCT awareness of Mr A's private work, through the job plan process and their private patient identification and management processes.
2. Establish the extent to which Mr A's private work interacted with HSC services and facilities.
3. To identify all of Mr A's patients that changed status (private/NHS) and check that there is evidence that relevant guidance/authorities have been adhered to. This will include providing assurance that:
    - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patient's clinical priority for treatment as a Health Service patient.
    - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient.
    - The Consultant fulfilled all obligations with regard to recording and identifying private activity.
    - Where private work was conducted on HSC premises, ensure the patient has been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

Limitation of Scope: Internal Audit would caution that the analysis conducted is largely based on the data provided by the Trust. Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete.

Executive Summary

Internal Audit has identified issues with Mr A's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly that than the Trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance in particular the change of status process and their ability to monitor that patients transferring from private to NHS care, are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

Received from Dr Maria O'Kane on 01/04/22. Annotated by the Urology Services Inquiry.

In total in the review period, 5 of Mr A's private patients were identified as having been treated at the Trust without/prior to receipt of a change of status form. A further 8 patients were potentially private when they were seen in the Trust (excluding those cases that the Trust believe are poor administration rather than private work). 5 patients switched status more than once (from NHS-private-NHS). 6 change of status patients were seen ahead of Trust waiting times. A further 2 patients were added to PAS retrospectively effectively being placed on the waiting list ahead of where they should have been placed.

In addition to private practice issues, there are also patient safety matters identified in the report primarily around performance of Pre Operative Assessments.

The findings of the review are summarised as:

Trust Processes and Awareness of Mr A's Private Work

Trust Knowledge of Mr A's Private Work

1. The Trust were aware that Mr A holds a private outpatient clinic at his home. It is unclear what happened these private outpatients if they required diagnostics and/or inpatient/daycase procedures. The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatients work only.

Job Planning & Payment

2. In line with job planning guidance and Consultant terms and conditions, a job plan review should take place annually. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018.
3. Personal Information redacted by USI [redacted]

The Trust's Change of Status Process

4. The Trust's Change of Status form for when a private patient transfers to NHS treatment, has limited monitoring or control value. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management. The Change of Status form itself and the Change of Status process require strengthening.
5. The Trust is not compliant with the regional guidance issued in 2018 which requires all Change of Status patients to be identified with a 'PTN' code on PAS.
6. The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

Identification of Private Work

7. Laboratories, Radiology and Pharmacy are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.
8. There is insufficient control over prescriptions pads to prevent the use of Trust prescription pads for private work.

Mr A's Change of Status Patient Activity

Approved Effective Change of Status Date

9. Contrary to Trust written procedure, the date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director.

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Change of Status Patients who had Diagnostic (Radiology) Tests

10. In 10 out of the 21 Change of Status cases during the period from January 2019 to June 2020, the patient was referred for 1 or more imaging tests. In 3 of these 10 cases, the patient had the imaging tests in the Trust prior to changing status to NHS ie whilst still private patients. A further 5 out of the 10 patients had diagnostic requests made on the same date as the effective change of status date and the same date the patient was last seen privately. Given that these 5 Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
11. 3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test.

Patients who changed Status and had Inpatient/Daycase Procedure

12. Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had their procedure during the review period (ie up to June 2020). The Trust Consultant Urologist assisting Internal Audit in this review considered that 2 of the 5 patients were not seen in line with the Trust waiting list time. These cases were not Urgent/red flag procedures (as categorised on PAS) and were seen significantly sooner than other patients on the waiting lists.

Retrospective Entry to PAS

13. Two change of status forms had been added retrospectively to PAS. Most significantly, one of these patients was added to the waiting list from September 2018 but this was not actually added to PAS in May 2020. At December 2020 this Change of Status had not been approved by Medical Director.

Protected Reviews

14. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.
15. Internal Audit identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list and therefore seen ahead of NHS patients with the same clinical priority.

Multiple Switches in Status

16. Contrary to guidance, in 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

Analysis of Mr A Activity Data

Pre-Operative Assessments (POAs)

17. In 86 (25%) of the 351 procedures conducted by Mr A during the period January 2019 to June 2020 which required a Pre-Operative Assessment, a POA was not completed.
18. Upon further analysis, 1 of these 86 cases related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.
19. 95% of the POAs completed on Mr A patients during the review period were completed less than 3 weeks before admission for surgery. The Trust requires POAs to be competed at least 3 weeks before (and up to 13 weeks before) admission for surgery,
20. The lack of POA or the short time scales between the completion of a POA and the date of admission for surgery is a potential indicator that a patient may have been seen privately and then had their procedure in the NHS.

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Elective Surgery With No Outpatient Appointment

21. Out of a sample of records where a patient had surgery but there was no evidence on PAS of an outpatient appointment, we found:
    - 1 patient changed from NHS to private and back to NHS status in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment. In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
    - In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. *It should be noted that the Trust believe that these are poor administration issues rather than private patients.*

Elective Surgery with an Outpatient Appointment

22. Out of a sample of 29 patients who had an elective procedure and an outpatient appointment in the period under review, 4 occasions were found where the patient may potentially have been a private patient. In one case the patient was a Personal Information redacted by the USI and in another case the patient was a Personal Information redacted by the USI *It should be noted that the Trust believe that one of these cases associated with non completion of an outcome letter is poor administration rather than a private patient.*

Other Observations

23. Other issues have been noted by Internal Audit around the audit trail when ordering scans on NIPACS (Sectra); changes being made to the referral date on PAS (which should not be changed); registrations for episodes of care on PAS that remain open rather than being closed; and use and monitoring of electronic sign off on NIECR.

Extent of Trust Involvement with CURE

24. CURE - Craigavon Urological Research & Education – is an independent entity, separate from the Trust. Whilst a number of Trust staff sit on the CURE Committee, these roles are independent from their role in the Trust. From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years. Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding and if granted, a cheque will be written from CURE to the applicant. Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.
    Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over any payments made by CURE to Trust staff.

Received from Dr Maria O'Kane on 01/04/22. Annotated by the Urology Services Inquiry.

Detailed Findings Of The Review

1. TRUST'S AWARENESS OF MR A'S PRIVATE WORK AND MANAGEMENT OF COMPLIANCE WITH PRIVATE PATIENT GUIDANCE

1.1 Job Plan Document

The Consultant Job Planning - Standards of Best Practice (November 2003) and Consultant Terms and Conditions of Service (Northern Ireland) 2004 states that a job plan review should take place annually. A similar requirement is contained in the Medical and Dental terms and conditions 2008.

Internal Audit requested a copy of Mr A's job plan for the period 1 January 2019 to 30 June 2020. In line with the annual job plan review schedule, there should be 2 job plans to cover this period. There is no signed off job plan held by the Trust for the period 1 April 2011 to 30 June 2020. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018 and there is no end date recorded. This document is not signed by Mr A or his Clinical Director.

The most recent job planning meeting appears to have been held in November 2018. Regular, annual job plan meetings have not been held.

1.2 Trust Knowledge of Mr A's Private Practice

"A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (An Agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland) (November 2003)" requires that Consultants declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work.

Trust procedures "Trust Guidance on Paying/Private Patients – 2018 states:
In section 2.2 "Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser"
In Section 5.1 "While Medical Consultant staff have the right to undertake Private Practice within the Terms and Conditions of the Consultant Contract (2004) as agreed within their annual job plan review, it is the responsibility of Consultants, prior to the provision of any diagnostic tests or treatment to:

- *ensure that their private patients are identified and notified to the Paying Patients Officer.*
- *ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.*
- *ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, hospital charges.*
- *Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.*

Although there is no private work identified in Mr A's most recent job plan, the Trust were aware that Mr A conducted private work outside the Trust:

- Mr A submitted a Trust "Declaration of Private Practice" in February 2018. In this declaration form, Mr A advised that he did not complete private practice within the Trust, however he did

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treat private patients outside of the Trust. The declaration form is not sufficiently clear to clarify the type of private practice undertaken (ie outpatient/daycases/inpatients). On the Declaration Mr A did not confirm that he had read and understood the Trusts Guidance on Paying/Private patients. He did declare that he understood that any private patient work whether undertaken inside or outside of the Trust must be included in his job plan. *The Trust Declaration of Private Practice process should be conducted every year. A declaration therefore should have been made by Mr A in 2019 however this was not submitted to the Trust and the annual declaration process was not conducted in 2020 due to COVID-19.*

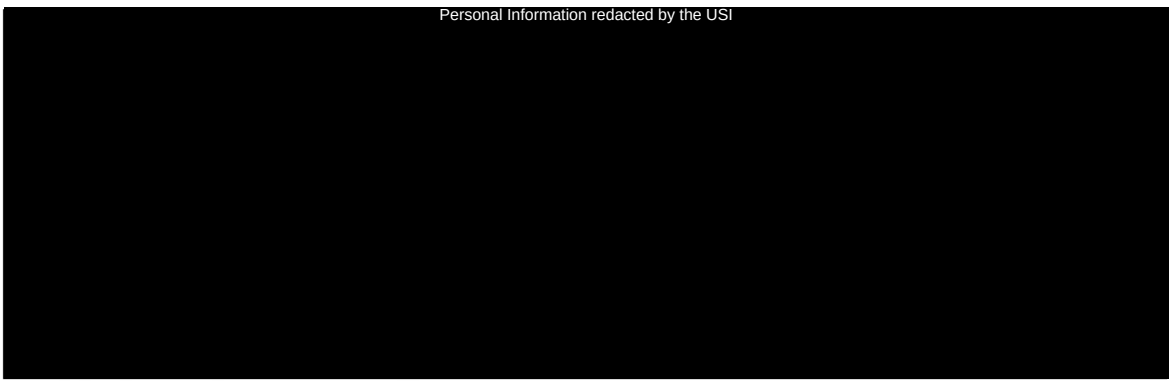
- The most recent appraisal completed for Mr A was in 2018. Internal Audit do not require access to this appraisal document, however the Trust have confirmed that Mr A declared that he conducted a private outpatient clinic at his home.

In the event that a private outpatient seen at Mr A's home clinic required diagnostics including blood tests or a daycase/inpatient procedure, it is unclear how this private activity was administered and whether or not such work entered the Trust either as private or NHS work. This issue is considered further in sections 2 and 3 of this report.

The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatient work only.

1.3 Reconciliation of Job Plan to Payroll

Personal Information redacted by the USI



1.4 Change of Status Process

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust Guidance on Paying/Private Patients procedures require Consultants to complete a Change of Status form when a private patient transfers to NHS treatment. However, effectively this form has limited monitoring or control value because:

1. The form is signed by the Consultant and stamped as approved by the Medical Directors office. It is not possible to establish who applied this stamp or the date it was applied. The change of status forms are filed in the cash offices at Craigavon Area Hospital/Daisy Hill Hospital and no

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action or reporting takes place within the Trust. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management.

2. The form contains no detail of the reason for the change of status.
3. The date the patient changes status to NHS is recorded on PAS as the effective date as per the Change of Status form, not the date the Change of Status form was approved by the Medical Director. This appears contrary to Trust Guidance on Paying/Private Patients procedures which state *"It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."* The Change of Status form is confusing this matter, by including an effective date of change of status rather than, an approved date. The form does not clearly state that the approval date will be the date of transfer to NHS from private status.
4. There are no dates applied to the change of status form by either the Paying Patient Officer on receipt of the form or by the Medical Director's Office on approval of the form. Therefore Internal Audit were unable to establish whether the Change of Status forms were approved prior to the patient receiving an appointment/treatment, potentially impacting on income that may have been due to the Trust.

Prior to 11 September 2018 when the regional PAS Technical Guidance approved a code (PTN) to identify private patients transferring to NHS status, the Patient Administration System (PAS) did not require a change of status to be recorded on the system. The change of status may have been entered in a free text field which is not a mandatory field. The Southern HSC Trust has not yet implemented the regional code 'PTN' for patients transferring from private practice to NHS. A PAS report cannot therefore be run showing all change of status patients.

The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

1.5 Private Patient Identification Processes

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

Internal Audit met with senior staff in Laboratories, Radiology and Pharmacy to discuss the processes in these departments for the identification and management of private patients. All three departments are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.

Pharmacy:

When a consultant prescribes medication to a private/NHS patient at an outpatient clinic, there are 2 different prescription pads used:-

- Prescription which can be written and given to the patient to take to the hospital pharmacy for dispensing. These are numbered but there is no control over the issue of the prescription pads. These are in quadruplicate – White copy –to GP, yellow copy to Pharmacy, Blue copy community nursing and pink copy patient notes.
- Prescription letter which the patient must take to their GP and the GP writes a prescription for dispensing at the community pharmacist.

There are inadequate controls surrounding the issue and use of prescription pads. Pads are held in consulting rooms and may be used by multiple consultants who apply their own name labels to the scripts.

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If a patient takes the script to the Trust pharmacy for dispensing, the pharmacy have no mechanism to identify whether the patient is private or has come from a NHS outpatient appointment. Similar to the rest of private practice, the Trust are reliant on the Consultant declaring activity as private and in this case, writing the prescription advising that the patient is private so that pharmacy can ensure that the cost of the medications are invoiced.

Internal Audit discussed 6 sampled cases with Pharmacy to identify if any of these patients had received medication while still private patients. No issues were identified.

Laboratory Services:

The Head of Laboratory Services advised that within the Trust they are reliant on the Consultant/doctor who completes the laboratory request ticking a box to identify a private patient. There is no other mechanism to identify private patients.

Laboratory results are put on NIECR and there is nothing to identify private tests unless the consultant has declared this on the lab request.

Diagnostic Services:

The Head of Acute Information in conjunction with the NIPACS Manager confirmed referrals received for scans etc are all completed on the same referral form and there is no mechanism to identify private or change of status patients on the system. Consultants order scans etc directly themselves on the NIPACS (Sectra) system.

As per Section 2 of this report, radiology activity was identified that should potentially have been declared and treated as private.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 1.1	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.
Management Action	ACEPTED
Responsible Manager	Medical Director and Director of Acute Services
Implementation Date	October 2021

General Recommendations Regarding Trust Process:

Internal Audit completed an audit in 2019/20 (finalised in October 2020 following delay in obtaining Management Response to the report due to COVID-19) and provided limited assurance in relation to Management of Private Medical Practice (including patient change of status processes). A number of the recommendations included in the 2019/20 report have been restated throughout this report.

Recommendation 1.2	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should

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	disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	Februaury 2022

Recommendation 1.3	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.4	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.

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Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance,
Implementation Date	February 2022

Recommendation 1.5	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	October 2021

Recommendation 1.6	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. *Previously reported in 2019/20* • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. *Previously reported in 2019/20*
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 1.7	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable.

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	The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.
Management Action	**ACCEPTED** The Trust have now set up two codes PHS & PTN, 1 for Inpatients and 1 for Outpatients. A report has been set up in Business Objects and shared with the Private Patient Officer to cross check. All secretaries have reminded of codes and when to use them.
Responsible Manager	Assistant Director Systems Assurance, Assistant Director Functional Support Services
Implementation Date	February 2022

Recommendation 1.8	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Diector ATICS
Implementation Date	February 2022

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2 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – CHANGE OF STATUS PATIENTS

2.1 Change of Status Activity During the Period January 2019 to June 2020

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.
The Trust's procedures and Change of Status form states "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."

Internal Audit requested all of Mr A's patient Change of Status forms for the period January 2019 to June 2020, from the cash office at Daisy Hill Hospital. Internal Audit were provided with the database which recorded 21 Change of Status Patients.

Internal Audit requested and reviewed the 21 Change of Status forms completed by Mr A from January 2019 to June 2020 and noted the following issues:

- 16 Change of Status forms had the Medical Director stamp on them as evidence of approval but it is not possible to establish who applied this stamp or the date it was applied.
- 4 Change of Status forms were still with the Medical Director at the 7 December 2020 awaiting approval. The dates that these patients transferred to NHS as per the change of status forms ranged from 2 - 14 months earlier than December 2020. Internal Audit were unable to establish when the forms were received in the Medical Directors Office.
- 1 Change of status form had been physically signed by the Medical Director, approximately 10 weeks after the effective Change of Status date.

2.2 Management of Patients Transferring from Private to NHS, Joining the HSC waiting list

Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) states:
"A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing."
"No patient should proceed –except in emergencies – to an investigation or treatment in a Health Service hospital until some mechanism has been applied which makes their status clear. Whichever system is introduced it must be capable of identifying the patient's status at every stage."

Internal Audit reviewed PAS data (provided by the Trust) for the 21 patients who changed status from private practice to NHS during the audit period January 2019 to June 2020. 13 of the 21 Change of Status forms related to day case or inpatient referrals and the remaining 8 forms were for outpatient appointments.

A range of issues were found in respect of Mr A's practice and administration of these 21 Change of Status cases (as outline below). However the issues also demonstrate the inadequacies in Trust monitoring processes around Change of Status patients and the limited control in the current process. The following issues were identified on review of the Change of Status forms:

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Approved Effective Change of Status Date

The date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director. *This is contrary to Trust's procedures and Change of Status form which state "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."*

On all 21 Change of Status forms, the effective date of transfer to NHS was the same as the date the patient was last seen privately.

Change of Status Patients who had Diagnostic (Radiology) Tests

In 10 of the 21 change of status cases, the patient had been referred for a diagnostic test (radiology) in the period 1 January 2019 to 30 June 2020:

- In 3 of the 10 cases, the diagnostic work was performed prior to the date of change of status. This diagnostic work was performed at a time when there was no referral on PAS for the patient ie whilst they were still a private patient.
  - One patient had a change of status date of 31/08/2019 – this patient had 2 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a Change of Status date of 09/11/2019 - this patient had 3 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a change of status date 09/11/2019 and had 1 imaging test requested in June 2019 with the test performed in July 2019 whilst still private.
- 5 of the 10 diagnostic tests were requested on the same date as the effective change of status date and the same date the patient was last seen privately (according to the Change of Status Form). Given that these Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
- 2 of the 10 Change of Status patients had an exam/diagnostic test requested after the effective date on the Change of Status form (1 was 3 weeks, 1 was 4 months). However given the weaknesses in the Change of Status process, it is unclear if this NHS test was performed after the change of status was approved.

3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test:-

- 1 of the 3 patients identified as private (above) was seen within 6 weeks against a waiting list of 21-32 weeks (at least 15 weeks earlier than Trust waiting time). This patient was seen in South Tyrone Hospital.
- For 1 patient the Trust waiting time for the imaging was 16-20 weeks and the patient had their imaging test within 5 weeks of request (at least 11 weeks earlier than Trust waiting time).
- For 1 patient the Trust waiting time was 5-10 weeks and the patient had their imaging test within 3 weeks of request (at least 2 weeks earlier than Trust waiting time).

Patients who changed Status and had Inpatient/Daycase Procedure

Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had subsequently had their procedure. The other 8 patients, whilst added to waiting list, had not had their procedure as at June 2020.

Internal Audit in conjunction with Senior Trust staff reviewed the patient journeys of the 5 cases who have had their inpatient/daycase procedures. All 5 cases were classed as URGENT on PAS per the report received by Internal Audit.

As part of this audit review, a Trust Urology Consultant considered the waiting times for treatment in the context of the clinical priority and Trust standard waiting times. The Consultant advised that:

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- 3 cases were in line with Patient Target List (PTL) waiting times/ for the procedure for the relevant clinical priority.
- 2 of the 5 patients were not seen in line with the Trust waiting list time. The Trust Consultant Urologist assisting Internal Audit in this review considered that these cases were not Urgent/red flag procedures and were seen significantly sooner than other patients on the waiting lists:
  - Patient 1 - the time between being added to waiting list and the procedure taking place was 23 days (approx. 3 weeks). The PTL waiting times for the same procedure for Mr A patients at this time were between 15 weeks and 217 weeks so we can conclude this Change of Status patient was seen much quicker than other patients waiting on the same procedure.
  - Patient 2 - the time between being added to the waiting list and the procedure taking place was 12 days. The Consultant Urologist advised that given the symptoms, this patient was seen much quicker than other patients requiring the same procedure at that time.

Retrospective Entry to PAS
Through review of change of status patients on PAS, it was noted that two change of status forms had been added retrospectively to PAS:

- One patient was added to the waiting list from 09/09/2018 but this was not actually added to PAS until 12/05/2020. At December 2020 this Change of Status had not been approved by Medical Director.
- One patient had a Change of Status on 11/10/2019 however the patient was not added to PAS by the consultant secretary until 01/02/2020, 4 months after the Change of Status.

See section 6 for related registration issue.

2.3 Protected Reviews

Internal Audit understand from the Trust that most Consultants retain a number of protected review appointments at each of their outpatient clinics. These slots should be for patients that the Consultant needs to see urgently (for example cancer patients) however there is no documented Trust procedure around the use of protected review clinic slots. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.

Internal Audit were advised that the central booking team at the Trust are responsible for booking new and review outpatient appointments. However Mr A's secretary was responsible for booking Mr A's Protected Review appointments.

Internal Audit have not specifically tested Protected Review bookings however we identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list. Internal Audit queried this case with the Trust and the Consultant Urologist agreed that the protected review appointment had not been used for the correct purpose and therefore the patient would have been seen ahead of NHS patients with the same clinical priority.

2.4 Capturing and Invoicing of Private work Conducted on HSC Premises

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

As per Trust procedures no private activity was declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices have been raised for private treatment – both indicating that Mr A did not perform private work on HSC premises.

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However, as outlined above, upon review of the 21 Change of Status Forms, Internal Audit noted cases whereby Mr A's Private Patients had received treatment in the NHS while still being a private patient.

Furthermore as described below, there are examples of patients seemingly switching several times between private and NHS and potentially receiving private treatment on the NHS, without declaration or charging. As per the *NHS A Code of Conduct for Private practice and* The Trust Change of Status Form – *"Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private practice"*

In 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

- In one case the patient had been under the care of another urology consultant within the Trust around the time of seeing Mr A privately.
- In one case from the review of PAS it was determined that the patient has seen a number of urology consultants and had been NHS and moved to Private and then subsequently transferred back to NHS.
- One patient had been seeing another Urology Consultant in 2018 and was called for a follow up outpatient appointment in July 2018 but didn't attend. It would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 17/08/2019.
- One patient had been under the care of the Trust at 31/01/2019 and was due for review at the end of 2019. This appointment was delayed and it would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 15/02/2020 and added the patient to the waiting list.
- One patient who had been added to the Elective waiting list for a procedure on 09/11/2019 (effective date of Change of Status) but had a consultation with Mr A in early March 2020 which is not on PAS. This patient would have had a procedure done in late March 2020 except for COVID-19 resulting in all elective procedures being cancelled from approximately w/c 16 March 2020.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 2.1	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.
Management Action	**ACCEPTED** This has been considerd by the Trust and it was felt it would not be appropriate to charge these patients.
Responsible Manager	Medical Director
Implementation Date	July 2021

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General Recommendations Regarding Trust Process:

Recommendation 2.2	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Functional Support Services and Operational ADs
Implementation Date	February 2022

Recommendation 2.3	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework *Maintaining High Professional Standards in the Modern HPSS should be followed*.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Also see recommendations in section 1

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3 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – DATA ANALYSIS

Internal Audit completed data analysis using information provided by the Trusts Acute Informatics department. Internal Audit were provided with the following reports from PAS, TMS, Pre Operative Assessment Unit:

- Patient Level List of Elective Inpatient Admissions, Daycases and Regular Attenders for Mr A Date of Admission only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Outpatient Attendances (Including Outpatient Urodynamic Attendances) for Mr A Appointment Date only between 01/01/2017 and 30/06/2020 from PAS
- Patient Level List of Outpatient Urodynamic Attendances for Mr A Appointment Date Only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Imaging Exams Performed which were Requested by Referring Clinician Mr A Exams Performed between 01/01/2019 and 30/06/2020 from NIPACS
- Patient Level Report of Theatre Cases Carried out by Mr A – By hospital, theatre and operation date based on operation date between 01/01/2019 and 30/06/2020 from TMS.
- Pre-operative Assessment Database for Urology with the Trust Identifying Mr A's patient's for pre-op assessments performed between 01/01/2019 and 30/06/2020

3.1 Pre-Operative Assessments

All elective patients who require a General Anaesthetic whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. The Trust deem the optimum time to complete a patients' POAs is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team 6 weeks in advance of the theatre date.

Theatre rotas are compiled by the Head of Service for Theatres, detailing which surgeons have access to the theatres at each session. When Consultants become aware of the theatre rota they then select the patients for each list, any who require pre op should be sent to the pre op assessment unit. Mr A selected his own patients and arranged his own theatre lists. It is understood that Mr A would have provided his secretary with a list of patients to be booked into his theatre lists and she would have completed an "Arrange Admission List".

Completion of POA

According to Trust PAS report provided, during the period January 2019 to June 2020, there were a total of 1,096 elective procedures performed on 576 of Mr A's patients. In consultation with the Head of Urology and Pre-operative Assessment Manager, Internal Audit analysed a PAS report of all elective procedures performed on Mr A's patients during January 2019 to June 2020. With the Trust's expert input, we were able to eliminate procedures where a pre op assessment was not required from our analysis. These cases related to procedures done under a local anaesthetic; or where the patient had previous surgery and the previous POA was still valid.

For 351 of the 1,096 procedures performed by Mr A, a POA was required. In 86 (25%) of these 351 cases, a POA was not completed. Internal Audit reviewed these 86 cases with the Pre-Operative Assessment Manager and found:

- In 24 procedures, the patient was assessed upon admission rather than having a scheduled POA ahead of time. An appropriate POA in line with Trust requirements was not therefore conducted.
- 62 procedures required a POA for the procedure but this was not completed. In 2 of these procedures, the patient did not attend/complete their POA but a POA had been requested in both cases. Both patients underwent surgery nonetheless.

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Lack of POA as Potential Indicator that Patient was Seen Privately and then Treated in NHS

Internal Audit reviewed these 86 cases further from information on PAS and NIECR to establish if there was any information that pointed to these 86 cases being private patients. This work identified:

- In 49 procedures, the patient had an appropriate footprint on PAS.
- For the remaining 37 procedures, the patient had either no outpatient appointment (according to the PAS data provided by the Trust) or there was a short timeframe between being seen at an outpatient appointment and the date of surgery. Internal Audit selected a sample of 23 of these procedures for further analysis on PAS and NIECR in conjunction with the Head of Urology. In 22 of the 23 procedures whilst a pre-op assessment was required, the patient was not deemed to be private as they had come in initially through ED and been given date for surgery on discharge, another Speciality or another Consultant was involved in their care. 1 of the 23 procedures related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.

Timeliness of POA

As outlined above, the optimum time for a patients' POAs to take place is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. In effect, PoAs are valid for a period of 13 weeks pre-admission for surgery.

On review of 265 procedures where a POA was undertaken for Mr A's patients, Internal Audit noted:-

- There were only 8 procedures (3%) where the POA was conducted within the timescale required by the Trust, in advance of surgery.
- 252 procedures (95%) were added to the POA list less than 21 days before their admission:
  - 105 procedures (40%) were added to POA list 5 days or less before admission
  - 131 procedures (49%) were added to POA list 10 days before admission
  - 16 procedures (6%) were added to POA list between 11 and 20 days before admission
- In 5 (2%) cases, there was insufficient information to confirm the timeliness of the POA.

3.2 Elective Surgery With No Outpatient Appointment

From the PAS data received from the Trust Acute Information Department, Internal Audit joined elective surgery data in the period 01/01/2019 to 30/06/2020 to outpatient appointments in the period 01/01/2017 to 30/06/2020. The purpose of this analysis was to establish patients who had surgery but did not have an outpatient appointment potentially indicating that they may have been seen privately for an outpatient appointment by Mr A prior to surgery.

Note: We considered outpatient information for a longer period than the audit period to factor in the waiting list times.

We found that there is no record of a Trust outpatient appointment (either pre or post surgery) for 220 patients who had at least one elective procedure (total 284 procedures) between 1 January 2019 and 30 June 2020.

Where a patient had surgery and no outpatient appointment, the patient could potentially have been a private patient as the normal patient route for elective surgery is to be seen at an outpatient appointment and then if required, listed for elective surgery.

Internal Audit reviewed the 284 procedures where there was no recorded Trust outpatient appointment on PAS. With the expert input of Head of Service for Urology, 138 records were excluded from further analysis because the nature of the procedure did not involve the need for an outpatient appointment (for example stent replacement/removal); or the waiting time for the procedure appeared in line with Trust waiting list; or the patient (5 cases) was declared as a Change of Status patient.

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Out of the remaining 146 records, Internal Audit selected a sample of 54 records (relating to 50 patients) which the Head of Service for Urology then reviewed on PAS and NIECR, particularly considering whether referrals had been received for these cases and where patients had been seen in relatively short-timeframe that there were valid clinical reasons for this. Internal Audit then walked through 21 of these 50 patients with the Head of Urology to validate the data. This work identified:

- 1 patient who was initially referred by a GP in January 2018 but was then discharged from this referral on PAS in July 2019 to attend Mr A privately. This patient was added to Mr A's Day Surgery waiting list from the same date in July 2019 as an Urgent case. This was done retrospectively on PAS on 20 August 2019, approximately a week before the patient had their Pre-Op Assessment in late August 2019. The patient had their procedure in early September at CAH Day Surgery Unit, 2 weeks after being entered onto the waiting list on PAS (albeit the entry was made retrospectively to an earlier time in July). The Trust has advised that the normal waiting time for this procedure is 91 weeks.
  In effect, this patient changed from NHS to private and back to NHS in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment.
  In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
- In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.3 Elective Surgery with an Outpatient Appointment

There were 812 records (356 patients) out of the 1,096 (576 patients) that had elective procedures who also had an outpatient appointment in the period under review.

From review of a sample of 29 of these patients, Internal Audit noted 4 occasions where the patient may have potentially been a private patient:

- 1 patient (Personal Information redacted by the USI) who had been seen privately by Mr A in 2017 was then seen in 2020 in the Trust as an NHS patient. A change of status form had not been completed.
- 1 patient was under the care of another urology consultant on PAS but the patient was seen by Mr A. There was no rationale as to why Mr A became involved in the patient's care.
- 1 patient was seen within 2 days of a red flag referral. Internal Audit observed that as per a letter on NIECR, this patient was a Personal Information redacted by the USI.
- In 1 case, there was no outcome letter completed following the procedure, which potentially could be an indicator that the patient may have been reviewed privately following the procedure. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.4 Other Observations

During the course of the audit, Internal Audit identified a number of other issues:

- There were 371 radiology diagnostic tests requested by Mr A from Urology Outpatients in the period 1 January 2019 to 30 June 2020 where the patient had no outpatient/surgical procedure, as per the PAS reports provided by the Trust. Upon further investigation and sample checking by Internal Audit in conjunction with the Head of Service for Urology, Head of Diagnostics and a Urology Consultant, it was identified that these cases were not all Mr A patients. When a junior doctors signs in with their own log-in into NIPACS (Sectra), their request will default to the last Consultant they ordered a scan on behalf of. The junior doctor should amend this to the name of the consultant they are actually making the request on behalf of, however Internal Audit was advised that this is not routine practice. Therefore scan requests are being attributed to

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consultants when the patient wasn't actually under their care. If a consultant makes the request themselves, this is not an issue as system maps directly to them it doesn't default to the last user. This means the audit trail on the system in terms of the requesting Consultant is incorrect in some cases and could mean that the test results go to the wrong Consultant, potentially creating a patient safety issue.

- The referral date on PAS, which is the date the referral of the patient is received by the hospital and will be the date the patient enters any relevant waiting lists, should not be changed however the date can be changed on the system. Internal Audit noted instances where the date had been changed, affecting the patient's position on the waiting lists. In the context of this audit, Internal Audit observed referral dates being changed to later dates rather than earlier dates.
- When a patient is entered onto PAS, a registration will be opened for the episode of care, this registration should be closed when a patient is discharged with their treatment complete. Open registrations on PAS should be reviewed on an ongoing basis. Instances were observed where the patient had been discharged but the registration had not been closed.
- Up to 2020 there was no mechanism for electronic signoff on NIECR. From 2020 this became available and is reportedly monitored however it is not routinely used across the Trust. Internal Audit queried how the Trust ensures that consultants are getting their own patient results – and where advised that there is a monthly check completed of all patients who are recorded as "DISCHARGE AWAITING RESULT" by Consultant secretaries. Internal Audit were advised that this is not conducted routinely. Internal Audit were advised that there 1,000 records on NIECR not signed off by Mr A.

General Recommendations Regarding Trust Process:

Recommendation 3.1	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.2	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.3	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.
Management Action	**ACCEPTED**

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Responsible Manager	Director Performance & Reform
Implementation Date	February 2022

Recommendation 3.4	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 3.5	The processes surrounding electronic and manual sign off and review of the **"DISCHARGE AWAITING RESULT"** should be strengthened and monitored.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Medical Director Clinical Directors and Assistant Operational Directors
Implementation Date	February 2022

See also recommendation 1.4

4 INTERACTION OF MR A's PRIVATE WORK WITH HSC SERVICES AND FACILITIES

A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (November 2003) states that HSC facilities, staff and services may only be used for private practice with the prior agreement of the HSC employer.

Internal Audit were advised by the Trust that Mr A's private practice did not interact with HSC services and facilities. However as per the findings in this report, there are a number of issues and exceptions that would indicate a degree of interaction – particularly for services that could not be performed or delivered from Mr A's home practice.

The queries around the timing of changes of status outlined in this report, mean there is a risk that Trust staff have been involved in the administration or treatment of patients that should have been categorised as private.

General Recommendations Regarding Trust Process:

See recommendations in section 1-3

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5 CRAIGAVON UROLOGICAL RESEARCH EDUCATION (CURE)

In line with the Terms of reference of this review, Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

According to the Companies House website/Articles of Association, a previous Trust Chairperson and Mr A set up CURE in 1996 as a 'Charitable Company Limited by Guarantee and not having Share Capital'.

The objectives of CURE are:

- To advance education for the public benefit in Urological disorders.
- Conducting and commissioning research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research.
- Raising public awareness and understanding of Urological disorders and their treatment and promoting training in the treatment of Urological disorders.

The CURE committee is currently made up of Mr A and three other people - 2 of whom are current Trust employees (1 Consultant Urologist and 1 Specialist Nurse in Health Promotion). The CURE committee secretary is a previous Trust employee.

Whilst these Trust staff are members of the CURE Committee, Internal Audit were advised by Senior Trust staff that their role should be separate and independent from their roles in the Trust. Internal Audit met with the two Trust staff who are currently on the Committee of CURE who both confirmed that their role within CURE is entirely independent of their job with the Trust. The Trust advised of some historical Trust involvement with CURE (pre-creation of SHSCT) including preparation of CURE accounts. Internal Audit also note that the registered office of CURE (until July 2012) was on the Craigavon Area Hospital site.

From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years.

Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding. A written request is completed and will be reviewed/approved by the CURE committee. If approval is granted by the Committee, the staff member will pay for the course and on submission of relevant paperwork invoices, a cheque from the CURE bank account is made payable to the applicant.

It should be noted that Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over payments made by CURE to Trust staff.

Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.

General Recommendations Regarding Trust Process:

Recommendation 5.1	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to

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	reputational damage to the Trust.
Management Action	ACCEPTED
Responsible Manager	Director of Finance
Implementation Date	December 2021

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Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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