21. With NICER the issue re patient notes has become less and so people have found ways around missing notes. There are still 13 sets of notes missing and he has been asked about them. I have no recollection of anyone using IR1's to document missing notes.

22. The Consultants working through the notes and undictated clinics have some concern that other appointments to other specialities have been missed as the letters were not dictated. There are no significant patient complaints regarding Mr O'Brien. The waiting lists are now so long so we have complaints generally about waiting times. Mr O'Brien does not use digital dictation and therefore it is not possible to monitor when clinics haven't been dictated. All of the other Consultants use digital dictation which allows for every clinic to be linked on PAS. If a clinic is not dictated this would highlight it. Consultants are using digital dictation 3 to 4 years now. While there is nothing specifically documented, my expectation would be that Mr O'Brien's secretary should have been flagging if outcomes were not dictated. I am now aware there are hundreds of letters from clinics not dictated by Mr O'Brien.

23. Mr O'Brien knows his patients really well but has kept a lot of the information relating to his patients retained in his head. It is not safe clinical practice.

24. An issue which concerned me this week is that when I checked regarding bed pressures, Mr O'Brien has no clinical priority noted on the theatre list. He said they are all urgent and 'they will all be done'. We need to be able to prioritise patients when there are bed pressures so we know who can be cancelled if absolutely necessary. The only person who knows the priority is Mr O'Brien.

25. In respect of TOR 4 – I was notified via e-mail from Mr Haynes about concerns relating to Mr O'Brien's private patients. Currently checks are ongoing on all patients in 2015 and 2016. The current waiting time for a routine procedure in Urology is 170 weeks. There does appear to be patients taken out of chronological order and operated on sooner. This is being looked into further to see if there were specific reasons for clinical priority in these cases.

26. Mr O'Brien says he has 4 categories of prioritisation; semi urgent, urgent, soon and routine, or something like that. This Trust has 2 categories urgent or routine. The rest of the urologists follow that.

*This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.*

*This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.*



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

d. In addition to the weekly report from the RBC, additional reports were sought if there was any indication that referral letters were not being triaged as required.

e. The assurances were given by the Head of the RBC who provided the data as a report from the RBC IT system and Martina Corrigan, the Head of Service for Urology, who had the day to day intelligence on the ground with the service.

f. The system put in place to rectify this problem was successful in identifying when referrals had not been triaged in the required timescale. However, the 'work around solution' depended on other consultants being prepared to address the fact that their colleague, Mr O'Brien, was not always and reliably prepared to undertake this work in an acceptable manner, i.e., within the required time standards.

g. Answered above at f.

50.7 Scheduling of patients for urology surgery with due regard to clinical urgency and chronological order.

a. This issue was raised by the Chief Executive in the meeting of 1 December 2009. The issue of scheduling patients in chronological order within the categories of urgent and non-urgent is a requirement of good clinical practice, whether this is for an outpatient appointment, or for day case or inpatient surgery.

b. The steps taken to risk assess the impact and to consider any impact on patient care and safety were to review the lists of people waiting for day case and inpatient surgery. As Mr O'Brien had no control over the booking process for an outpatient appointment as this was the role of the RBC, the focus was on the inpatient waiting list. The process of scheduling patients for both day case and inpatient surgery was usually undertaken by the



Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

consultant supported by a specific scheduler in the administrative staff. The process for scheduling Mr O'Brien's patients for surgery was changed to include the Head of Service in addition to the Operational Support Lead for Surgery and Elective Care.

c. Answered above at b.

d. The scheduling of individual patients for a specific day case list and inpatient list on a specific day had been previously undertaken by Mr O'Brien with his secretary. No one else had been involved, or perhaps been allowed to be involved, in this process. The process implemented to address the issue was that the Head of Service and the Operational Support Lead (OSL) for SEC would work with Mr O'Brien to schedule patients for each list. Mr O'Brien chose to use a different type of ranking of urgency which had 4 levels rather than was the usual practice of 3 levels. (Mrs Martina Corrigan confirmed for me at my request that this was the process put in place to manage the booking of Mr O'Brien's patients for surgery.) This on occasion, resulted in the amending of a patient's urgency ranking for surgery, resulting in minor changes in dates for a patient's surgery. These changes linked to the clinical indication for surgery necessarily are the judgement of the clinician.

e. The assurance that these systems were working as anticipated was through the OSL and Head of Service who reported to the AD, and myself. The assurances were tested by an evaluation of all those patients on the waiting list for surgery with particular reference to those waiting for surgery due to a diagnosis of cancer. In the detailed review of long waiting patients undertaken on a frequent basis the length of waits against the referral date was reviewed as a matter of routine in order to identify any patients waiting outside their order by urgency and chronology.

f. Answered at e above.



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g. The systems put in place with the OSL and Head of Service working with Mr O'Brien were successful as they removed the sole control of the scheduling of surgery from Mr O'Brien, and ensured that the scheduling rules were applied. The performance indicators were the evaluation of the list of patients waiting and performance reports setting out the Primary Targeting List (PTL) for surgery and how long each patient had waited.

h. Answered at g above.

50.8 Surgical operation of cystectomy (excision of the bladder)

a. The concern was raised by the Commissioner on 1st September 2010 through a letter sent to Dr Loughran, Medical Director, and copied to myself and Mr Mackle, AMD. Dr Corrigan drew the Trust's attention to a slightly increased rate of cystectomy for benign pathology in Craigavon Area Hospital when compared with the rest of the NI region. The number of patients identified was of the order of 2-4 per year. The letter from Dr Corrigan to Dr Loughran is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2*

b. The immediate step taken was a meeting held on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy Director of HR and Organisational Development and myself. At this meeting it was agreed that a formal independent review of the appropriateness of the treatment of cystectomy was required. The action determined was to commence a 'local review' in line with the guidance provided by the document 'Maintaining High Professional Standards in the HPSS''. This process included a case note review of each patient who has undergone a cystectomy in the previous 10 years.



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regional Radiology system it was eventually possible to see on the system which reports had been read by the consultant who had ordered the test. This ensured that reporting could be in place, once the requisite report software was written and the system updated. As the radiology system was implemented as a regional system this reporting function only became available after the Root Cause Analysis report was completed and the problem would have been difficult to identify earlier through formal systems. I do not recall whether a report on the monitoring of the consultant sign off of test results in the radiology system was made available during my tenure.

i The laboratory IT system was developed to ensure that there was sign off of each blood test by the doctor who had ordered the specific blood tests. Any discrepancies were monitored and followed up. This process of developing reporting was undertaken within the Trust by the Laboratory Head of Services in the Acute Services Directorate and was not linked to a regional system.

ii The scheduling of patients in order of urgency and chronology was addressed through a stronger process of scheduling involving the Head of Service and the Operational Support Lead scheduling patients with Mr O'Brien, a process not required with other consultants. This ensured that Mr O'Brien no longer had sole control of booking patients for surgery.

iii Patients requiring the operation of cystectomy for either malignant or benign conditions were transferred to the Belfast Trust as part of the implementation of the regional review of urology.

iv The use of IV therapy for patients with recurrent UTIs was addressed through the development of a multidisciplinary process of discussion involving the consultant urologist, the CD for surgery and a consultant microbiologist prior to the treatment commencing for each patient. This ensured that the use of oral antibiotics was fully discussed and IV



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a. IV therapy was to be stopped for all patients in the cohort receiving such treatment - A new pathway for these patients was agreed between the consultants including Mr O'Brien and Shirley Tedford, the Urology Services Coordinator in September 2010.If in the view of Mr O'Brien a patient still required admission for IV therapy, then he was required to discuss the patient with the Clinical Director for Surgery and a consultant microbiologist to reach multidisciplinary agreement of the best approach for the patient which may have been oral antibiotics.

b. Triaging of red flag referrals and non urgent referrals was to be completed in the time standards set out in the IEAP for NI - This was agreed on more than one occasion.

c. Scheduling of patients for theatre by urgency and chronological order - The Head of Service was aware of the different approach to scheduling taken by Mr O'Brien and took active steps on a permanent basis to ensure the correct approach was taken in discussion with him when scheduling each theatre list. The Head of Service was supported in this approach by the OSL for Surgery. This approach was accepted by Mr O'Brien.

d. All Radical pelvic surgery patients to be referred to the Belfast Trust from summer 2010 - The process to undertake this was put in place in September 2010, as was required through the Implementation of the Urology Review. This was not a matter of agreement with consultants, rather a requirement for patient safety to ensure that surgery was being undertaken by a smaller group of surgeons who were undertaking these major procedures more frequently than would have occurred in a smaller urology unit such as CAH.

e. Adoption of different new to review ratios in outpatient clinics in order to implement the Team South Urology service model and release outpatient time for new referrals and review appointments - Whilst this was not formally agreed by Mr O'Brien, the new clinic templates were commenced mid November 2010. After implementation an adjustment with 2 fewer new patients per clinic had to



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We will have to closely monitor the returns of the named referrals though and Anita can you please ask Katherine to let us know early if there are any problems arising?

Re charts at home, I think we all agree this is just not acceptable.

Thankyou all for your help

Heather

From: Young, Michael
Sent: 02 December 2013 15:28
To: Brown, Robin; Trouton, Heather
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Have spoken and offered help with the triage issue – will reinforce again this week

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Heather
I wonder if could you call me on the phone to discuss this I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient Personal information redacted by USI Personal information redacted by USI so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

regularly come up to the Director for Acute Services' office informally to touch base there. I'd regularly go to the Assistant Director's Office and the Heads of Service Office and touch base with them. I'd informally regularly make contact with the Clinical Directors, both by telephone, in person, by e-mail. As surgeons, the Clinical Directors are also surgeons, we would often see each other in theatres when our sessions were at the same time and we would be able to catch up and touch base at that time as well. The informal network was much easier to maintain than the formal network, which had rigid dates and times sat to. 14:57 14:57

58 Q. I am conscious that you have said you weren't a line manager for any of your Urological colleagues. At any point, knowing what you knew about the reported shortcomings in Mr. O'Brien's practice, did you ever face-to-face him on any of those issues in your role as AMD? 14:58

A. I didn't. When these issues were raised with him, they were raised by his direct line manager which would have been his Clinical Director. 14:58

59 Q. Just for the record, that was Mr. Weir moving on to Mr. McNaboe?

A. Yes, but I didn't directly raise them with him.

60 Q. Was that because you didn't see it as your responsibility or was it some kind of reticence or perhaps professional embarrassment to do so? 14:58

A. I was a working colleague of Mr. O'Brien and I was aware of how he worked, as you know, from the concerns

I've raised. I was also aware that he was a challenge to challenge, and I knew that from discussions that we would have had as a group. I also had an awareness of his personal connections, if you like, with members of his family within the legal profession, his personal connections with the Chair of the Board, and the rumour mill had told me that a previous AMD had been accused of bullying when trying to tackle Mr. O'Brien. I guess the answer to why didn't I personally tackle him when I knew the Clinical Director was, is because I had to work within a team with him, I didn't want to -- essentially, it was a fear thing. I didn't want to find myself in a difficult small team working relationship as a result of the other bits that I was, if you like, aware of. I think, as I just said, grapevine, it's that sort of rumour mill, grapevine fear rather than anything documented, but that would have played a significant part in it. 14:59 14:59 15:00

61 Q. Just two points there before I move on. It was a small urological team of Consultants, I think six at that point. Is it not inevitable, as Associate Medical Director, that you are going to be dealing with a professional colleague and you will need to be dealing with a professional colleague on difficult issues, and the job simply can't function unless the post holder is prepared to rise above that and grasp the nettle, difficult though that might be in human terms? 15:00 15:01

A. I think so, but, as I said, when I came into post in

2014, and then as I came through and recognised issues, these weren't new issues; these were issues that had been attempted to be tackled with him before and had become part of almost -- I hesitate to say, it's almost accepted practice, he practised in this way and everyone else practised in another way. You know, we have talked about the notes at home. I'm not aware of anyone else who would be taking notes at home and storing them at home regularly, but that was accepted practice and almost everyone knew. Of course I should have tackled him personally, but I was coming in, if you like, late to this, with a many year history of other people attempting to tackle it to no success, and it becoming part of normal working arrangements for him. 15:01 15:02 15:02

62 Q. You do accept it essentially fell within your job description, notwithstanding this history, to have a fresh go at trying to tackle the issues?

A. Yes, and where other issues have arisen with other individuals, not necessarily within Urology, I have taken an active role in that, so it's specifically with Mr. O'Brien I didn't. 15:02

63 Q. The second issue you raised just a short time ago, which I intended to deal with later but I will deal with it now. You've suggested through the rumour mill I think was how you described it, a certain chill factor in terms of being able to deal with him, associated with what was known to be his family connections to the legal profession and his social 15:03

really, and seeking out help, seeking out support from a corporate perspective, as opposed to trying to keep it from within because they don't really want anyone to look at that.

159 Q. Finally then, you described the improvements in MHPS reporting. I think, you, yourself, suggest that's the tip of the iceberg, really, in terms of understanding all the informal issues and all the improvements you need to make. So I think from what you said that's been helpful in terms of increasing the discussion engagement at Governance Committee and, hopefully, at the Board in due course. 13:09 13:10

Have you seen any other improved engagement that fits along with the Just Culture kind of idea at Board level as a result of the work that you have had to do for this Inquiry and the work that others have had to do. Have you seen anything else filtering through that would be helpful for us to know about? 13:10

A. I think from a Board perspective, I mean there's very much that openness. There's the openness to bring problems at a much earlier stage and I think that is very much welcomed. I mean inevitably across different services, even Acute Services, there is issues and it is very much a full disclosure, there's an openness, there's engagement at an early stage to say "this is what we're dealing with". The discussion is had. There's the challenge there. There's the follow-up there. I suppose I'm seeing more of that. 13:10 13:11

160 Q. How does that feel as a Board member?
A. It feels much more comfortable and it feels much more safe, I think, because you're getting it out there at an early stage. You're seeking their views. So, yes, it feels comfortable. Probably in bringing the issues, 13:11
you know, from a Board perspective nobody wants to hear, you know, "we have an issue here". But I think it is very much seen in that light that it is helpful, it's the right thing to do, it's the open thing to do. And it is done in that way and it is accepted in that 13:12
way. I think it is a more supportive challenge, if that makes sense.
DR. SWART: Thank you. That's all from me. Thank you.
CHAIR: Do you have any questions?
MR. HANBURY: Thank you very much. Just getting back 13:12
to your comments about the success or otherwise of the informal processes back in March 2016 with this letter to Mr. O'Brien from Eamon Mackle, Heather Trouton, which is well-intentioned but ultimately didn't lead to where it should have done. Do you think you should 13:12
have been a bit more involved at that stage on reflection back or someone from Human Resources involved when...
A. I think we would have been able to contribute in a more, a tighter framework around it. I think we 13:13
would have signaled at that stage, you know, this is MHPS territory. But I think certainly at the very least, in terms of an actual letter and with a follow-up date, I think it would have been helpful to

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|---|---|
| | ➢ I can also see now how the busyness of the service and the constant tension between demand and capacity meant there may have been little time or room to become aware of issues or to triangulate information about issues or even to address issues. The pressure on various services across the Trust (not only Urology) may also have had an impact on some of the processes involving Mr. O'Brien (such as the MHPS process) given that they often involved a range of people, all of whom were carrying significant workloads. |

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

49.1

| | |
|---|---|
| Culture | ➢ An open and honest culture that is psychologically safe begins in the Boardroom. That culture then needs to penetrate throughout the organisation, no matter your role or perceived/actual level of authority or seniority.<br>➢ I have, since taking up the role of Chair, prioritised the issues of culture and how the Board works. I was very mindful that I was taking on a team of Directors who felt damaged and hurt. There was a need to build trust with each other and as a team. This work continues.<br>➢ The bringing of urgent issues to the attention of Trust Board can happen through a variety of ways. |



Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

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|---|---|
| | There should be no impediment to significant urgent issues, particularly those affecting patient safety, being raised. I am, since 2021, seeing issues/concerns being raised through Trust Board and Committees more readily than before. |
| Strengthening Internal Governance | ➢ The vastness and complexity of the work of the Trust carries with it a number of risks. These risks include that of silo working and silo reporting. The apparent manifestation of this risk in the Trust's Acute Services Directorate allowed issues in Urology that had a single common denominator to go unconnected for some time.<br>➢ I believe in this regard that there were missed opportunities to triangulate information (e.g., from the MHPS process and SAI Reviews) to identify a single common denominator.<br>➢ The Champion Review has allowed for a meaningful change in corporate and clinical social care governance. The creation of revised operational governance provides for more triangulation of information so that no one event is seen in isolation as in the case of Mr. A O'Brien |
| Stable Board and Senior Leadership Team | ➢ The recruitment of 6/8 Non-Executive Directors within a 12-month period meant the organisation lost institutional memory and experience. The inexperience of the new members in respect of the complexities of health and social care meant, for me at least, that we were not as prepared/equipped as we could have been.<br>➢ The implications for any organisation not having a stable and committed senior leadership team is a |



Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

Directors and Associate Medical Directors. They were not unique to me. During the Review of (Adult) Urology services I can confirm that the weekly Monday evening meetings could become quite fractious as the Department of Health were trying to get the Trust to agree to clinic activity. Mr O'Brien would not agree to the BAUS guidelines of 20 minutes for a new patient and 10 minutes for a review patient (this had been accepted in the other two Urology 'Teams' in Northern Ireland) and, whilst agreement was eventually reached, Mr O'Brien was in the minority as he wouldn't sign up to this activity and would quote this back to me over the years.

30.10 Mr O'Brien was very aggrieved with the Review of Urology Services (2009), particularly the removal of radical pelvic surgery from Craigavon Hospital and it was his view, and he said it on a few occasions, that patients had died as a result of this decision. Mr O'Brien would have openly said that Mark Fordham (external author of the paper) should never have been allowed to be involved in suggesting this recommendation.

30.11 Mr O'Brien didn't hide the fact that he didn't work well with Dr Rankin and Mr Mackle. Both of these managers tried to manage him through the IV fluids and antibiotic review, through radical pelvic surgery moving to Belfast, and through his continuous non-compliance to triaging the new outpatients. Dr Rankin and Mr Mackle would have persevered in holding Mr O'Brien to account which, in my opinion, Mr O'Brien didn't like as he was used to 'doing it his own way'.

30.12 Mr O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices.

30.13 I have an awareness of at least two occasions where managers had been asked to step back from managing Mr O'Brien. In approximately 2011/2012 Mr Mackle had been advised that he was being accused of bullying



Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

them, I didn't wish to look at them. I actually felt very -- it's a really odd one now again on reflection for me, but where my thought process went immediately on becoming aware of that, and I think I made it known to the legal teams, I felt particularly vulnerable around the 24th January meeting. I was a lone female in a meeting with three male colleagues, three male individuals. Bizarrely, I suppose, my thought process went to was this a video recording, what is this recording, who has this recording, where has it been kept, who has been watching it. I didn't know. So, those were all questions I had posed back through the legal team at that time. I suppose that was the impact that that had on me as a very immediate reaction. So, I suppose it just describes just how appalled I was at finding that out. 12:37 12:37 12:37

I suppose on reflection and over what has been quite a period of time, and I ultimately did then go through the transcript obviously in preparation for coming, I think I was particularly taken aback probably given who was in the room with me and the fact that, you know, there are probably meetings where we suspect that that may be -- you know, may be a feature and we are looking out for it. This was a senior consultant, a legally qualified support family member in the room. I suppose I was just completely blind-sided by the fact that this was something that would be done. 12:38 12:38

163 Q. The framework allows for the person accompanying

172 Q. We can see AOB-56226. Just scroll to the bottom of the previous page, please. So, Michael O'Brien asked:

"Have you spoken to all of the other witnesses now that you will be speaking to, that you have said you were going to be speaking to?" 15:21

You say:

"I think it's really important that we are clear about what this process is about. Okay. I am very happy for you to be here to support your dad but really a lot of this is for your dad and for Mr. O'Brien to raise queries or to raise concerns. You are here primarily for support really". 15:21

He says:

"If you prefer my dad to ask you the question, he will". 15:22

So, you weren't prepared to hear from Michael O'Brien, is that fair, or you wanted to control that?

A. Well, I felt -- I think the issue was complicated by Michael O'Brien's -- about Michael O'Brien's qualifications. You know, the MHPS allows for people to be supported by somebody and it says that they can be legally qualified, of course, but that really they are not there in a legal environment. I felt this was 15:22

# **Domain 2:** Safety and quality

## Contribute to and comply with systems to protect patients

**22** You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

**a** taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary

**b** regularly reflecting on your standards of practice and the care you provide

**c** reviewing patient feedback where it is available.

**23** To help keep patients safe you must:

**a** contribute to confidential inquiries

**b** contribute to adverse event recognition

**c** report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk

**d** report suspected adverse drug reactions

**e** respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.[14]

Withdrawn – 30 January 2024



Source: https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/archived-guidance/good-medical-practice-english-2013---2024.pdf

## Respond to risks to safety

**24** You must promote and encourage a culture that allows all staff to raise concerns openly and safely.[3, 15]

**25** You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

**a** If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

**b** If patients are at risk because of inadequate premises, equipment[13] or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance[15] and your workplace policy. You should also make a record of the steps you have taken.

**c** If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.[14, 16]

**26** You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.

Withdrawn – 30 January 2024



Source: https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/archived-guidance/good-medical-practice-english-2013---2024.pdf

**27** Whether or not you have vulnerable[17] adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.[18, 19]

## Risks posed by your health

**28** If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.

**29** You should be immunised against common serious communicable diseases (unless otherwise contraindicated).

**30** You should be registered with a general practitioner outside your family.

Withdrawn - 30 January 2024



Source: https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/archived-guidance/good-medical-practice-english-2013---2024.pdf

the clinician may have required. Is that something you acknowledge or - I know it was perhaps before your time, but is that a feature historically of appraisal that you understand and acknowledge?

A. I think that, and I think this stems from the GMC's relationship to appraisal. Right. I think at times it's neither fish nor flesh. So it was set up basically to be an opportunity for developmental learning for doctors and, you know, in its purist, in it's original purist days it was almost seen as something that was completely set apart that was only known to the appraisee and the appraiser, almost sat completely outside the system and didn't link. Now, as time has gone on I think - so it would have been seen as, you know, as an educational development tool, you know, in and around in the domains, the four domains that are within it. Increasingly the GMC has asked for evidence of it over the years and I think, you know, that gets used I think as an indication of the doctor's compliance with, you know, the willingness to understand their practice and develop, but also in terms of gaining their insight into their practice in terms of how they reflect and deal with their work. And I think - because it's called "appraisal" I think then it gets conflated with a performance management. Right. So I think that it gets seen in different ways in different places, when actually what we need is a job planning process, a performance management process that, you know, and performance in the widest sense in

11:16 11:17 11:17 11:17 11:18

that it's not just activity it's also about quality, safety, you know, user experience, all of those things.

65 Q. Mmm.

A. And then the appraisal, you know, if it's going to sit outside all of that, should be a developmental tool in relation to what comes from these other systems then to support the doctors. 11:18

So, I think it gets used in different ways. But, you know, in more recent times, and I appreciate that this has been an evolution, in more recent times it is a go-to place in terms of, you know, recommending the doctor for revalidation with the GMC in relation, you know, to give an awareness of how the doctor relates to their work, but also, you know, if there are concerns about a doctor, or if the GMC is looking for evidence about a doctor, before they will even ask for the job plan they will very often come and ask for you to give a feedback in relation to the doctor's appraisal in terms of how they are. So I think that has permeated the system to some extent. 11:19 11:19

66 Q. Yes. Well from your perspective as the leader of the organisation trying to drive a quality and patient safety agenda, what, within your command, can you do with appraisal to help support that agenda, and is there any evidence that it is being used to support that mission or vision for the Trust? 11:20

A. Well, what we have done is we have tightened up the appraisal calendar. So, you know, we do come with the

expectation now that - the appraisals are run within a calendar year, right, so it's January to December, and we do come with the expectation that those will be completed in the first quarter of the following year, right, and that they're robustly done, you know, along the four domains of the appraisal, but supported by other information, and that has developed regionally over the years and it is a shared regional template. So there will be statements there about health, and probity and, you know, declaring interests, all of those things should go in there. 11:20 11:20

But the other part of it I think increasingly is the reflection, and there would be an expectation within each of the domains that there would be a reflection done, but I think also a reflection that if a doctor is in difficulty over something that actually there's a reflection done on that specifically, because what you're interested in knowing is if, for example, there has been a complaint about their performance in relation to quality and safety or, you know, there has been a complaint made by a patient, actually how they take then that information and used that as an opportunity for improvement? So how we're trying to support that is through appraisee and appraiser training. So it's done rigorously across the Trust. You know, we have quite a lot of appraisers in relation to that, and also then we have - in relation then to the step beyond that which is, you know, when these get 11:21 11:21

looked at by - or the overarching themes from them get looked at, not the actual conversations get looked at - then whenever the Medical Director brings together the Divisional Medical Directors on a monthly basis to consider the overall appraisal picture within the Trust, any concerns that have been raised in relation to appraisal or a doctor's relationship with appraisal within the Trust, whenever they're having their overarching monthly revalidation meeting, that gives an opportunity then for some of this to be quality assured in terms of having a shared learning around it. 11:22 11:22

67 Q. And I'm going to coming and look at some of those conversations that happen on a regular basis between your Deputy Medical Directors and medical leaders within the services, notably the Divisional Medical Director. 11:22

Just before we leave appraisal, you have - am I right to observe that you've tried to build a better infrastructure around appraisal? 11:22

A. Yes.

68 Q. I was a little unsure when I looked at materials. Is there a senior revalidation and appraisal manager?

A. Yes.

69 Q. And does he or she work with the Deputy Medical Director who has appraisal and revalidation as part of their job title? 11:23

A. Yes. So Ms. Davidson oversees that and she brings together not just the appraisal and revalidation for

medicine, she also manages it for nursing, which has been really helpful, because on the back of some of the work that has gone on in relation to this, and then the parallel process that has developed in relation to the oversight of doctors in difficulty, the Director of nursing and AHPs has developed a similar system for nursing, and social work is now in the process of developing that for social work. 11:23

So some of the systems and processes that have been put in place to strengthen all of this, together with the support system that has gone in, is increasingly being adopted across the Trust. 11:23

70 Q. Yes. And just further in terms of the infrastructure. There's now a Trust Appraisal and Revalidation Board? 11:24

A. Yes.

71 Q. It's due to meet for the first time this month, I understand?

A. Yeah. Yes.

72 Q. And I suppose there's greater visibility around appraisal. The Medical Director provides a report for the Trust Board in relation to medical appraisal. I think we can see it at TRU-306108. So that's relatively fresh off the press. This is Dr. Austin's report January of this year. 11:24 11:25

A. Mm-hmm.

73 Q. If we just go over the page and pick up some highlights. He sets out areas of improvement, including a new process agreed to standardise the

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# WORKSHOP

## Handling concerns about a doctor or dentist

Zoë Parks – Head of Medical HR.

2023

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# Aim following workshop

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- Provide an overview of **MHPS Framework**
- Set out **practical steps** & understand when a concern may need escalated.
- Clarify how concerns should be **reported** to meet statutory needs of the Responsible Officer.
- Explore **Techniques** to promote handling in a fair way in an open & just learning culture.

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# Restorative Just & Learning Culture

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

*Dr. Lucian Leape*
*Professor, Harvard School of Public Health*
*Testimony before Congress on*
*Health Care Quality Improvement*

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

*Don Norman*
*Author, the Design of Everyday Things*

TRU-306135

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# The Practical Steps…

1. **Prompt / Consider Risk**

2. **Exploration to establish facts**
   a. Preliminary enquiry/Screening
   b. Or Full formal investigation.

3. **Define and take suitable action**
   - Remediation approaches where appropriate

4. **Review & Monitor**

**Remember: Record & Retain**

**Even if informal or no action taken**

Personal information redacted by the USI

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# 1. Incident Prompt & Explore

*Key questions:*

- 'What immediate action is required?'
- 'Is there enough information to resolve this now?'

*Principles:*

- Never do nothing, but avoid over-reacting - do only what is essential to safeguard patients until the facts can be established.

- Be prepared to seek advice, with a clearly understood and practiced local process, and important contact details to hand.

- Begin by assuming the doctor will engage professionally and that the matter can be resolved, whilst retaining awareness that whilst uncommon, some doctors are capable of deliberately unprofessional and criminal actions.

- Involve the doctor (*unless Fraud suspected) – their immediate response can often help determine if further action required.

# 2a: Preliminary enquiries/Screening

Is there an **agreement** (manager & doctor) that the facts can be established sufficiently by initial enquiry within an acceptable timescale, to allow safe and fair conclusion?

The doctor should be included **as a partner** in process.

Initial enquiry will involve **cross-referencing of information**.

**Time efficiency** is important, but it is also important to allow enough time to reach the right conclusions.

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# Defining a Concern & Thresholds for escalation

**Key question:** • Is the incident attributable to an individual and might it constitute a concern?

**Defining a concern:**

"Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice".

*Ref: "Supporting Doctors to Provide Safer Healthcare"*


**Assessing the Risk.**

- Familiarity with suitable risk assessment matrix can be helpful.
- Provide a degree of objective backing to professional judgement.
- These tools are not validated and do NOT replace professional judgement.

- **FIRST:** Consider the issue and form an opinion as to whether the associated risk is low, medium or high using your professional judgement. **Then** consider it against a risk matrix to test your perception.

- During Workshop - we will consider some examples and discuss how you might respond.

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# 2b: Formal investigation?

Formal investigation may be best when:

- The **risk is high** - a higher level of exploration may be necessary to maximize likelihood of successful resolution;

- **Complexity** - such that a lower level of exploration is unlikely to sufficiently establish the facts;

- **More serious** concerns

- **Absence of agreement** between the clinical manager and the doctor on whether the facts can be established sufficiently at a lower level within an acceptable timescale, to allow a safe and fair conclusion.

**Record should be kept (& shared with MD)** no matter what outcome

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# 3. Define & take suitable action

**Figure 2: Options for action**

| | | Options for action<br>At all levels personal reflection by the doctor is an important action | | | |
|---|---|---|---|---|---|
| | Risk | Educate | Supervise | Support | Define practice |
| Not a concern | Low (Insignificant) | • Standard PDP (doctor-led),<br>• College-defined standard CPD | • Normal, by line manager | • Informal support (e.g. mentoring, coaching) optional/self-directed | • Normal practice within scope of work presented at appraisal |
| | Low (Minor) | • PDP contains appraiser-led items.<br>• CPD may contain items directed by appraiser | • Normal, by line manager<br>• Responsible officer aware via appraisal | • Informal support (e.g. mentoring, coaching) optional/may be specified by appraiser | • Normal practice +/- minor adjustments to scope of work |
| Concern | Medium (Moderate) | • Expert (in-house or local external, +/- NHS Resolution/College) assessment of development needs to create targeted PDP and CPD requirements | • Responsible officer aware separately to appraisal<br>• Supervision in practice optional | • Informal support (e.g. mentoring, coaching) desirable | • Normal practice +/- adjustments to scope of work |
| | Medium (Significant) | • Expert external assessment (+/- NHS Resolution/College) of development needs to create targeted PDP and CPD requirements | • Responsible officer aware separately to appraisal<br>• Supervision in practice likely | • Informal support (e.g. mentoring, coaching)<br>• Desirable | • Significant restrictions to scope of work likely<br>• Exclusion from workplace may be necessary<br>• GMC investigation possible including potential interim restrictions on the doctor's registration. |
| | High | • GMC-led investigation of fitness to practise leading to targeted PDP and CPD requirements | • Responsible officer aware<br>• Supervision essential if not excluded | • Informal support (e.g. mentoring, coaching) desirable | • Significant restrictions to scope of work highly likely<br>• Exclusion from workplace likely<br>• GMC investigation probable including potential interim restrictions on the doctor's registration. |

## Most Common Interventions

**Supervision**

**Supervised practice**
**Formative work-based assessments (Mini-Cex; OSCE; Simulation, Multi source feedback; CBD's)**

**Development**

**Re-training; re-skilling, workshops, courses, e-learning, focused reading.**

Specialist interventions:
**e.g. behavioural coaching, counselling, specialist advice, Health advice or input.**

Practitioner support; **mentoring, protected learning time, career advice.**

Organisational support; **HR, Legal, Team or workplace mediation.**

**Scope of Work**

**Amendment, restriction or reduced scope of work**

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# 4. Review & Monitor

Key question:

- **Have the actions resolved the concern?**

*Principles:*

- A concern which has not resolved, requires **further investigation**
- Not all concerns can be resolved, continuing management may be necessary to assure patient safety.
- **Record & Retain** on central files - [redacted] Personal Information redacted by the USI
- **Trust Oversight Group** regularly reviews all reported concerns
- Reports to Chief Executive and Trust Governance Committee

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# At the heart of the framework

Whatever the source of information, the response must be the same (MHPS para 10 intro):

1. **Ascertain quickly what has happened and establish facts**
2. **Be quick to determine if there is a continuing risk**
3. **Consider if immediate action is required to manage risk to ensure the protection of patients**
4. **Decide on action to address any underlying problem.**

**At any stage:** NHS Resolution | Practitioner Performance Advice

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# Worked Example:

## SAS Doctor – Gastroenterology

Doctor Apple is a permanent SAS doctor in Gastroenterology, who has been in post for 4 ½ months. This is her first NHS post, but she spent 12 years in hospitals outside the UK prior to commencement (the last year at registrar level). She qualified overseas and has obtained MRCP UK.

Unfortunately the consultants have reported to you that she is struggling with the job and is not working at SAS grade level. She is a very quiet person and taking referrals are proving challenging for her. She is also unfamiliar with NHS systems. She shows very little in the way of Gastroenterology knowledge and there has now been a clinical incident, which the nurses have reported to you.

Feedback from consultants is that they simply do not have time to train up a SAS doctor (who they expect should have these basic skills) as they have lots of new NIMDTA training doctors in post following the recent rotation.

**How do you take this forward?**

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# Restorative Just Culture Guidance

CONTINUOUS IMPROVEMENT ACCOUNTABILITY

| STEP 1 – TRIGGER POINT |
| --- |

**TRIGGER / PROMPT**

**STABILISE**

*Address risk. Protect Patients*
Then ask what is needed?
Immediate Response

Additional supervision/ possible restriction OOH?
Compassionate initial response, Meet with the doctor & team to discuss incident; Listen to understand root cause. Ensure Support. Discuss needs and obligations for individual and service.

**SCREEN**

Explore and Gather Facts
Consult Restorative Just Culture
Action to address Concern

Address Clinical Incident. Gather facts – Evidence based: Consider all factors: systems/ training/ supervision/ peers etc. review training, induction/mentor/buddy, simulation (Southern Academy support). Consider PPA/NHS Resolution. Will need Time bound Action Plan with work based assessments. Document and record actions agreed. Monitor and review. Seek HR support re contractual particularly is no improvement.

**RESTORE**

Review & Monitor
Accepting accountability - What is the right thing to do?
Repairing trust / relationships
Forward looking accountability to avoid future harms

Regular follow up with review of action plan. Continue to support
Was an collaborative agreed way forward reached? Team building?
Have we managed to deal with organisation learning – resolved any systemic issues – perhaps in this case an inadequate induction?

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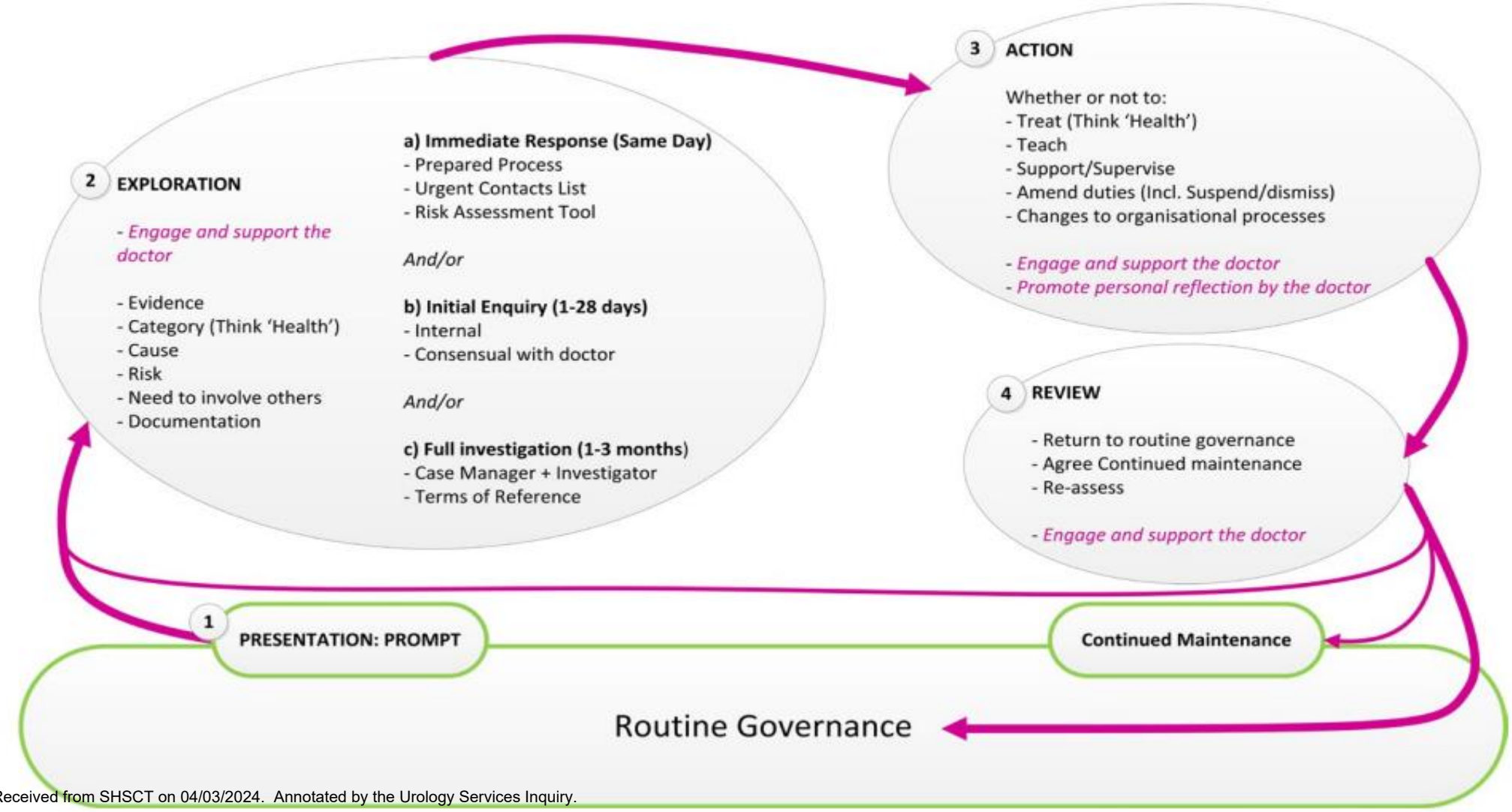
# Section I: Action when a concern first arises

**Figure 1: The process for responding to a concern about medical practice from initial exploration to action and review**

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STRICTLY PRIVATE & CONFIDENTIAL

| Case Study 1 | Specialty: Obstetrics & Gynaecology |
|---|---|
| Doctor Green | |

**Dr Green** is a consultant in your busy Obstetrics & Gynaecology service. He has been with the Trust for 15 years. The ward clerks have recently overheard him shouting down the phone whilst in his office and they are worried he is being rude to patients. The nurses have reported that he is behind in his administration and is sending other doctors to do his clinics. When the nurse approached him, he said far too much is expected of doctors nowadays and everyone just needs to back off. He often talks about leaving. His colleagues have commented: "That's just how Dr Green is, he is grumpy by nature".

**You have just become his Clinical Manager –**

1. **What information will you need to establish?**

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| Case Study 1 | Specialty: Obstetrics & Gynaecology |
|---|---|
| Doctor Green | |
| INJECT 1 | |

- You confirm his sickness record and on the last 3 occasions of sick leave, he was due to be on-call.
- You check his Job plan, which was last signed off in April 2020 for 12.75 PA's. His last appraisal was also completed in 2020.
- There is one patient complaint in the system received within the last 2 weeks. It does mention Dr Green's attitude amongst other things regarding the department in general.
- There are no known clinical concerns.

**How will you approach this case? How would you prepare for a meeting with Dr Green?**

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Case Study

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| Case Study 1 | Specialty: Obs & Gynae |
|---|---|
| Doctor Green | |
| Inject 2 – one *month after initial meeting* | |

- What happens if Dr Green has not changed his level of performance at your 1 month review meeting?

- He stresses that he feels burnt out and exhausted and is frustrated with the extra scrutiny. He comments he is one of the most senior doctors in the team.

- He has also just shared with you that he really doesn't get on with his new clinical colleague who joined the team 6 months ago.

- What interventions might you consider?

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Case Study

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| Case Study 1 | Specialty: Obstetrics & Gynaecology |
|---|---|
| Doctor Green | |
| ***Inject 3 – Around the 3 month review*** | |

- Unfortunately, there has still not been the expected improvement.

- Dr Green advised he plans to submit his resignation shortly. He asks you to provide him with a reference for a consultant post in the South of Ireland.

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Medical HR - Doctors-in-Difficulty-HUB (pagetiger.com)

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# Clinical Manager's Toolkit

https://view.pagetiger.com/Medical-Staffing/toolkit

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# Toolkit for Clinical Managers

Southern Health and Social Care Trust

**MEDICAL HR HUB - Click Here**

**Judging & Assessing Risk of Concern**
Preliminary Enquiries & Assessments Tools. Click Here

**Performance Management Toolkit**
NHS Employers

**Managing Difficult Conversations**
Business Disability Forum

**Preparing for Challenging Conversations**
Template

**1:1 Feedback Template**
*Conversations*

**Templates to help Supervision**
*Action Plan, MiniCex, TAB, CbD*

**Facilitated Meetings**
NHS Resolution

**NHS Resolution Interventions**
*Mediation/Facilitation/ Behavioural or Clinical Assessments/Action plans*

**Managing disruptive behaviours**
Adapted Royal College Surgeons

**Writing References**
GMC

**Workplace Behaviour Toolkit**
RCOG

**Supporting Doctors in Difficulty HUB**
*SHSCT*

**New to Clinical Management**
Signpost to Training Resources

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# Your Questions

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**Please** Scan to leave your Feedback (1 minute)

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## 2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

[1] Examples of Concerns may include: - when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.



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the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following



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599 Q. Do you know why?
A. I can't say. That option of bringing it up and having people in similar roles with similar problems of discussing it was removed. That's all minuted, it's all there. I don't know whether you have seen that, but it is there. 16:38
600 Q. I looked at some of those meetings.
A. There was a distinct trend from 2015 right through to September 2016 when it became, essentially, a useless meeting. 16:38
601 Q. Something slightly different. There has been a lot of mention of the Oversight Committee in the discussions that we've had. What was your understanding as AMD of the actual role, purpose, status, hour, of that Committee? Was it something that everybody understood well or? 16:38
A. No, not at all. It was basically -- it wasn't really a Committee, it was the Medical Director.
602 Q. So it was -- how did you see it then? Can you give us your view of how that operated? 16:38
A. The Medical Director -- this was a committee that looked at Maintaining High Professional Standards, GMC issues, and it was the Medical Director and it was the HR. The HR role, as I understood it, my experience of HR is they don't take responsibility. They give advice, they give you options, and then you make the decision, and then they ensure that due process is followed, ostensibly so it is fair but really so there is no chance of any comeback in any appeal or legal 16:39

process. Then there's a Director from whatever division is involved. But these are medical issues so the divisional director really has less of a call.

603 Q. So as Divisional Medical Directors it is my understanding in looking at the minutes that there was no attendance at these meetings even when it involved something in your division; is that right? 16:39

A. You mean for me?

604 Q. Yes?

A. No. 16:40

605 Q. So it was done without you?

A. I was never involved, ever, in Oversight Committees. That was always at Director level.

606 Q. What's your view of that? The appropriateness of that?

A. Totally inappropriate. But you need to have -- if you're going to have a Clinical Director there, they need to be someone who is prepared to be robust and to be prepared to be robust. I think for a Clinical Director it would be difficult. I think for an AMD it would be easier. 16:40 16:40

DR. SWART: Thank you. That's all from me.

CHAIR: Thank you. Mr. Hanbury?

MR. HANBURY: Thanks very much for your evidence and your remarks about surgeons! Many would say that a successful surgeon is a physician who operates. 16:40 Modern urology is a conversion rate of no more than 20 percent, so actually don't operate on more than we do.

I would also like to go back to your May, email, or

managers and I think I probably assumed with the Medical Director, because if it's an issue which involves a very senior doctor, the Medical Director is usually involved. So I would have been aware that there had been meetings which had led to this was an outcome from a previous meeting. 11:36

68 Q. Yes. You comment upon this in your report, about this letter not then generating any further action so far as you were aware. You have described that, and we will look at it later, as being a missed opportunity. When we look at that list of documents that you received as part of your briefing from Siobhán Hynds, there doesn't appear to be any reference to the oversight meetings that took place during 2016, of course until the 22nd December meeting that led to the decision to have a formal investigation. Nor, for that matter, do you see in what is briefed to you the advice that NCAS provided to the Trust in September 2016. Is it fair to say that you didn't spot that as an issue at the time? 11:36 11:37

A. I didn't spot it as an issue at the time, that's correct. I was aware that NCAS had been approached and that that was one of the reasons why the investigation was to be progressed under Maintaining High Professional Standards as opposed to a more informal route. But I was not provided with any written correspondence or advice from NCAS. 11:37 11:38

69 Q. If we just briefly look at the NCAS advice that came in in September 2016, AOB-01049. Again, conscious that you have never seen that document; is that fair?

A. That document was included in the bundle that I was provided for the purposes of this Inquiry --

70 Q. Yes, of course.

A. -- but I have not seen it prior to that.

71 Q. You didn't see it as part of your investigation? 11:38

A. No.

72 Q. Just scrolling down the page, this is the first advice the Trust received in the context of Mr. O'Brien's alleged shortcomings and what was to be done about that. Just going over the page, the Trust is advised 11:39 that:

"The problems with the review patients and the triage could just be addressed by meeting with the doctor and agreeing a way forward. We have discussed the 11:39 possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear and he will require significant support."

11:39

In terms of your approach to your investigation, did you know or have any appreciation that NCAS was advising the Trust that, in terms of dealing with some of the issues that were of concern, Mr. O'Brien would require, and NCAS was endorsing, the need to provide 11:40 him with appropriate support?

A. No, I wasn't aware of this NCAS letter or of the recommendations. I was aware that NCAS had been approached. I have thoughts on providing additional

support. I am not sure if it's appropriate for the Panel to hear.

73 Q. What I want to ask you is now that you see this kind of thing - and we will come on to look at why you included paragraph 5 in your terms of reference in just a short time - but given that you did include paragraph 5, was it not important that you had a full understanding of what transpired during 2016? 11:41

A. I felt I had been provided with enough information. I mean, terms of reference number 5 is about what management did in terms of if they knew that there were problems and how they tried to deal with them. So, I suppose I was looking specifically at that. I wasn't aware of this letter from NCAS. My understanding was that NCAS had suggested that -- 11:41

74 Q. There was, and this Inquiry knows, a sequence of events in or around the period between August and the end of the year when the decision was taken in December to have a formal investigation. I suppose what I wish to look at with you in the course of this is, having regard to the term of reference which you included at 5, should you have been able to investigate what happened during those six months, there was a series of oversight meetings, there was NCAS advice, there was a conversation between the Medical Director and the Chief Executive, the Medical Director and the Director of Acute Services, Mrs. Gishkori, and none of that seems to have featured as part of your investigation? 11:42 11:42

A. To my mind, term of reference number 5 was added by me

or suggested by me to the Case Manager. Really, what I believed I was looking -- the reason I raised it is because what I wanted to know is what had happened prior to sort of 2016 or the first half of 2016, I suppose. And I had no knowledge of what happened between August and December so I was really -- to my mind, I added that as well, what happened earlier in 2016, were there attempts to try and deal with it; what happened prior to 2016, were there attempts to deal with it? So I had no knowledge of what happened towards the end of 2016. 11:43 11:43

75 Q. Yes. Okay, we will come back and that will be one of the first areas we will look at.

CHAIR: 12 o'clock.

MR. WOLFE KC: 12 o'clock. 11:44

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

76 Q. MR. WOLFE KC: In terms of the e-mail we just looked at from Mrs. Hynds to yourself, 2nd March, there's just a brief point I want to draw your attention to. If we could have it back up, TRU-283049, and scrolling down. She suggests to you you should give Mr. O'Brien a call to introduce yourself, as the Case Investigator and to reassure him "we are moving forward with the investigation". 12:01 12:02

Did you speak to Mr. O'Brien?

A. I believe I did so but I can't completely recall.

have -- you know, we have taken all these concerns really seriously. I that what we have tried to -- certainly what I have tried to evidence in my statements around actually what -- you know, what we have learned and what we've done about it to try and improve on all of that so that, you know, hopefully reduce the risk of something like this happening again.

374 Q. Just a final question from me. It is just from left field, slightly. But when you worked in the Belfast Trust were you familiar with the doctor and dentist case review meeting? 15:57

A. Yes. So that was -- I was party to that on a regular basis. I was Deputy Medical Director for workforce and education, but mostly workforce. So I attended that on a regular basis. When I came to the Southern Trust, that structure wasn't there. It tended to be very reactive. So what happened was, if there were concerns, there was a director oversight group set up. So what we now have in place over the last -- I can't remember the start date of it but I know that we did a lot of work in terms of getting terms of reference and all those things sorted out -- but now we have a monthly meeting that has oversight from HR, the Medical Director's office and the operational directors, depending on who their doctors are, plus the divisional medical directors from each directorate, and all of that now systematically worked through and action plans developed. Then the out workings of that are now reported to me as Chief Executive. 15:57 15:57 15:58

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Medical and Dental Oversight Group

**Terms of Reference**
**2020**

**Summary & Purpose**

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

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

**Terms of Reference**

The panel will review the case files of all medical and dental practitioners employed in the Trust, or engaged via Agency for whom there concerns have been raised about their professional practice. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed or was employed at the time concerns arose. Termination of employment, for whatever reason, does not necessarily end Trust responsibility in terms of MHPS or regulatory Fitness to Practice procedures.

Concerns about professional practice shall include;

- all Fitness to Practice procedures with regulatory agencies,
- all practitioners subject to procedures under MHPS (or equivalent procedures for doctors in training),
- restrictions, undertakings, suspensions or other sanctions imposed by a regulatory agency,
- all cases where NCAS have provided advice or assessment,
- all practitioners subject to a remediation process,
- practitioners whose performance has been called into question through appraisal and/or governance systems (as determined by the Responsible Officer),
- and all doctors for whom a recommendation to revalidate could not be provided at the time requested by GMC.

The Oversight Panel shall regularly review each case file with the Medical/Dental manager for the practitioner.

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The Oversight Group shall ensure that any investigations taken under the management of performance comply with relevant guidance and occur in a timely manner.

The Oversight Group will at all times have due regard for ensuring patient safety.

The Oversight Group is required to provide additional assurance to the Trust that procedures under MHPS are undertaken in a fair and proportionate manner

All procedures under MHPS will be undertaken in accordance with this guidance and **SHALL NOT** be delayed until the next meeting of the Panel.

## MEMBERSHIP

The members of the Medical and Dental Oversight Group will comprise:

- Responsible Officer / Medical Director (Chair)
- Senior Manager MD Office
- Director of HR / Deputy Director of HR
- Head of Medical HR
- Associate Medical Director and/or Relevant representation from the Service (as set out below)*

*The Director or a nominated deputy.

The Oversight Panel may request additional members (including a legal representative) to provide expertise in particular areas. In the event of a member being unable to attend meetings an alternative professional representative may attend on his/her behalf.

## ROLES AND RESPONSIBILITIES

***To be discussed and completed here after further discussions with AMD's***

The oversight panel shall consider each case and may give direction on further actions required. If the practitioner is a doctor in training then the Director of Medical Education and/or a representative of NIMDTA shall attend.

All meetings will be attended by a minute taker. Detailed minutes will be recorded of each meeting and retained.

All meetings will be chaired by the chairperson or in his/her absence, by a member nominated by the chairperson.

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*It is best practice that AMD's discussing cases at the Oversight Panel should ensure individual doctors are aware of the above process and that their case may be discussed as part of the Trust's process for handling concerns.*

**QUORUM**

The Panel will not normally meet unless 2 members are present and meetings can only take place if the chairman (The Medical Director) is present or a nominated deputy.(Deputy Medical Director)

**FREQUENCY OF MEETINGS**

Meetings shall be held monthly

**REPORTING ARRANGEMENTS**

Minutes of the meetings of the Panel will be formally recorded and action notes distributed to Panel members and a full copy retained on the Medical Directors file.

**REVIEW OF TERMS OF REFERENCE**

The Terms of Reference will be reviewed at the first meeting of the Forum and thereafter annually. Any amendments to the Terms of Reference will be approved by the Medical Director; in the event of significant changes to the Terms of Reference these shall be presented to SMT for approval.

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150 Q. Would it have been the natural approach to go to the AMD?
A. I had spoken to Mr. Haynes, yes.
151 Q. What about the Clinical Director?
A. I know that Mr. Haynes had spoken to the clinical -- I think the Clinical Director at that point in time -- again, there was quite a switch in people at that point in time was either Mr. McNaboe or Mr. Weir. Certainly he wasn't getting -- I think it may have been Mr. McNaboe at that point in time. He wasn't getting any concerns at that time. 12:03 12:03
152 Q. Did you ever speak to Mr. Young about Mr. O'Brien as the Lead Clinician?
A. No. Not until after -- no, I hadn't any conversation with Mr. Young until, I think, autumn 2020. 12:03
153 Q. Did you ever speak to Mr. O'Brien? Did you ever go and see him and speak to him about issues?
A. No. I haven't spoken to Mr O'Brien.
154 Q. Did you ever meet him?
A. No. 12:03
155 Q. Were you at any meetings with him ever?
A. No.
156 Q. Do you think, in hindsight, it might have assisted in getting a better insight into managing him or finding a way forward if there had been a meeting at that level? 12:03
A. In my mind, right, and again I think I was wrong at that point in time. In my mind, he was being managed through a system of escalation, and everything else.

and that very often they were trying to do other jobs and get this done for me at the same time. So there was that aspect of it. I think, you know, some of the electronic systems had only been developed about 2016/2017, so in terms of getting information beyond that was really problematic. Again in terms of the systems then bringing together, for example, Serious Adverse Incidents, complaints, it all seemed to be dealt with in silos down through the different Directorates but not shared or given oversight by the Medical Director. Again, I think historically there had been a view that governance was managed by the Operational Directors and the Medical Director was there, then, basically to comment or give an opinion on some of the processes, without it being a full assurance process. There was very little audit going on of actually governance processes. There was very little, I think, transparency in relation to how some of those things were done. Again, back to my earlier comments in terms of trying to get information, if I asked for anything at all that was governance related, and given at this point in time I was mostly concentrating on the Acute Directorates and, to some extent, the Mental Health Directorate which also was undergoing significant challenge at that point in time too, it took an inordinate amount of time to get the information. Then sometimes it wasn't of good quality and you had to go back and ask for it again. Then you had to try and make sense of how it all fitted

12:40 12:40 12:41 12:41 12:41

people feel comfortable to work, to discuss, to have differences. It requires people to know that the patient is at the centre of what they are doing and first and foremost, of what their outcome should be focused on. That doesn't always exist in multidisciplinary teams. That takes work. That takes effort. That takes insight. Without that, you will not get the positive goals and the additional benefit that the teams are set up to deliver for patient care. I think when it says: 10:39

"You must communicate relevant information clearly to your colleagues, to those who work within Services and to patients". 10:39

I think that's critical to what we are dealing with today. Patients and professionals should know when they are working in a multidisciplinary team that, when treating a patient, they have to feed back information about changes in plans. They have to make sure the team is informed, that they have oversight and governance of the care that the team is delivering, and also other colleagues who work within other services, so if there are issues they must escalate it to their line managers, their Clinical Managers and their Service Managers. 10:40

The other issue here is we talk about patients. Healthcare can be very complex. It can be very full of

jargon, but you need to have mechanisms so that patients can fully understand the care they are receiving and fully understand the options they have around treatment, and that should be done in a highly supportive way with a multidisciplinary professional input. 10:40

25 Q. Jumping slightly ahead to the findings of your reviews that I will explore with you later, you found communication problems right throughout these arrangements; isn't that right? For example, the Cancer Services Management, I think it was your conclusion, didn't appear to be well-connected to the multidisciplinary team or well-connected to Urology Services. Can you explain that just briefly to give us a taster of what lies ahead in this communication context? 10:41 10:41

A. DR. HUGHES: Yes. Initially talking to the Senior Clinical and Managerial Cancer team I would have expected them to have oversight, knowledge and experience of what was happening in each MDT. I would have expected them to have a corporate view of the patch. I would have expected them to have joint meetings with all the different Leads, taking best practice from the more mature MDTs. Classically in Northern Ireland the more mature are the better resourced ones, such as breast and colorectal and lungs because they have been formed the longest. I didn't see that. I found it virtually an adversarial relationship between the team and the Urology Services. 10:41 10:42

your broad experience? Can you help us with that?
MR. GILBERT: By broad concerns is that it becomes very difficult to raise concerns at all levels. That's not particularly about protecting your own reputation, your own income. Yes, consultants are usually appointed in 12:06
their late 30s, they have young children, they have been moving around often, apart from their families for many years, and finally they get this job that allows them to settle. Risking that is quite a big step to take, school and children, mortgages to pay and so on 12:07
and so forth. The Health Service should have systems in place in order to protect those individuals in those circumstances when they wish to raise a concern. I am not confident that the Health Service has those mechanisms working in place. They may be there in name 12:07
but I do not believe that they are functioning.
MR. WOLFE KC: Thank you for that.

Dr. Hughes, is there anything you can further assist us with in that sort of particular respect, how the Health 12:07
Service can build greater confidence into its systems to encourage people to speak when it is appropriate to speak?
DR. HUGHES: We have to recognise we wouldn't be in this place if the Health Service wasn't so 12:08
hierarchical. There are known and problematic issues, especially in Northern Ireland where 80 percent of the medical graduates come from one medical school and everybody knows everybody else, and that adds another

difficulty. I think what you need to take it back, what is an issue? It is actually a patient issue. Park the name, park the person, park whatever. If something is affecting patient care or patient outcomes, or potentially, people should be in a flat environment where they can have these difficult conversations. 12:08

For a multi-disciplinary team to have that conversation, it needs to be fully cognisant of their roles and responsibilities; it needs to know how their behaviours affect everybody else, and they need to be reminded of what their primary duty is, it is to keep patients safe. If anybody has a concern around that matter, that should transcend any other issues. 12:08 12:09

That being said, human beings being human beings, you have to deal with the human factors around that and we're not good at doing that. I think this is a case in point. People had concerns but didn't have a meaningful way of escalating them, and didn't really want to deal with them in a confrontational manner because that will not resolve anything. I think this is a much wider conversation we're having than just this issue, because how do you -- you know, a stressed environment, an MDT that's not fully functioning, is not appropriately resourced and doesn't have oncologists on a regular basis, how does that address its own internal problems? It's probably not going to 12:09 12:09

18 The Inquiry Panel agrees and believes that a failure by a clinician to take seriously administrative and appraisal obligations may be indicative of an attitude which needed to be challenged more robustly at an earlier stage. Proper enforcement of a medical practitioner's administrative and appraisal obligations is a critical component in the relationship between the Trust, as employer, and the consultant as employee. Although it is much easier to view in retrospect, the combination in Dr Watt's case of lone working, consulting with perhaps the highest number of neurology patients, and persistent administrative failure should also have given rise to questions about the oversight of Dr Watt's clinical practice.

### Medical Culture & Medical Managers:

19 At the heart of the problems identified in this report was a medical culture, which had not yet come to terms with a managed system. The Inquiry Panel heard from a wide range of witnesses, and it was apparent that the commitment of doctors and other health professionals to their patients is, by any standard, impressive. Medical professionals were, however, apprehensive in raising a concern about the practice of a colleague or querying discrepancies that arose, which did not directly touch upon the welfare of their own patient. It was clear that senior managers were too often reluctant to manage doctors and were easily deflected by the raising of any clinical dimension to an issue of concern. Correspondingly, many doctors who took on a management role were accustomed to operating collegially and consensually and found the responsibilities of management did not easily fit into that extant culture.

20 Evidence reveals that clinical directors are expected to fulfil a significant management role at the same time as practising as a doctor. The posts are taken up by busy clinicians, who are given limited hours to carry out the role. The Inquiry Panel's assessment of the evidence is that this resulted in an impoverished understanding of management by doctors and, in some cases, a sense that the focus of the role is to represent the interests of one's specialty. The Inquiry Panel concluded that the role was often taken on by senior doctors out of a sense of duty. As the posts were for a period of 3 years, the perception developed that those senior clinicians have an obligation to take their turn. At the end of the 3-year period, a clinical director will normally go back to full time clinical practice.

21 The fact that a consultant may be outstanding as a clinician does not necessarily translate to being competent as a manager. The roles are distinct and require very different skill sets. This has not been adequately understood either by the higher echelons of Trust management, or by the medical profession. In the view of the



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Inquiry Panel, an unjustified reliance is placed on the structures created when there is often a disconnect between the policy of the Trust and the managerial approach taken within a specialty. The Inquiry was tasked to consider only the position within Neurosciences but has no reason to believe that the situation is otherwise in different medical specialties.

22 The sense within the Trust is that because consultants are highly trained and academically able individuals, they will be able to move easily into a management role. Training for the role needs to be strengthened and an understanding of the accountability aspects of management reinforced. The reality is that for a clinical director or a clinical lead to hold his/her own colleagues managerially to account, in the system that currently operates, is a challenging requirement. For those doctors who have advanced further in medical management and who are more removed from day-to-day interaction with colleagues, the difficulties of managing colleagues are less acute.

23 The position of the Medical Director is, in the view of the Inquiry Panel, the critical role in the current structure from a patient safety perspective. The importance of disclosing relevant information to the Medical Director's Office cannot be overstated. In the case of Dr Watt, the Inquiry Panel believes that without the then Medical Director's response in December 2016, to concerns that had been raised, and more particularly in July 2017, there is no guarantee that the problems identified in the recall would have necessarily emerged.

24 A pre-existing and deeply rooted medical culture which inhibits a flow of relevant information to the Medical Director's Office was, in the view of the Inquiry Panel, a major factor in failing to identify potential problems with Dr Watt at an earlier stage. Consultants are used to having ultimate personal responsibility for their patients. In relation to clinical care, they are at the head of a clear linear decision-making structure. This contrasts with their role as an employee within a managed organisation where the flow of information is more restricted, and as the Inquiry Panel has found, clinical management roles lack the same clarity. This leads to friction within the broader management framework.

25 The evidence received by the Inquiry Panel would suggest that many doctors, by training, impose their own filters and thresholds of proof that often have the unintended consequence of failing to escalate concerns. Such an approach impedes pattern recognition. Information, which, when collated and analysed together may give rise to concern, has been excluded because a doctor has concluded that a concern he or she had, is not sufficiently serious to escalate.



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26 In a sense, doctors conflate the approach they take to their own practice and the clinical judgements they make on a daily basis, with the view they take if they have a concern about the practice of a colleague. The filter applied seeks to have the maximum degree of investigation and assurance before committing to a position. With their own patient(s), that may not present a difficulty; they have the benefit of full medical notes and records, a detailed examination and full history and a clinician, fully briefed, can consider the appropriate treatment. In contrast, when coming across an issue of concern with a colleague, the doctor sees only in part, rarely has access to the medical notes and records, has not conducted a full examination or taken a full history and is, by definition, not in as good a position to make a judgement.

27 In such circumstances, doctors appear wary of committing themselves to a position. A concern identified may fail to meet the threshold in their own mind. Consequently, matters which may urgently need investigation or a further review, are passed over. Such an approach is not the standard imposed by regulators or required by employers. If a concern is reasonable, it should be escalated and checked. It is not the function of the doctor concerned to reach a definitive view or conduct an investigation.

28 The current system seeks to model a collective leadership approach. The triumvirate structure with separate medical, general management and nursing lines of authority reporting to a Co-Chair (Medical) and Co-Director (General Manager) under the respective oversight of the Medical Director and a Director at Board level is purposely collegiate. The danger is, however, that when everyone is responsible, no one is responsible, and the evidence given to the Inquiry catalogues a number of occasions where information was shared, and/or lines of accountability appeared not to have been understood.

29 A narrative developed following the announcement of the recall process in April 2018, that nothing of substance regarding Dr Watt's practice was known by the Trust until a concern was raised by a GP in November 2016. This Inquiry has found that such an understanding was far removed from the actual position. Information was held, both inside and outside the Belfast Trust, which if it had been properly collated and analysed, could have led to earlier intervention.

### Concerns Raised:

30 The Inquiry also considered in detail the question of concerns being raised by various medical personnel including registrars and nursing staff. The Inquiry found



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significant evidence that concerns had been raised and had not been appropriately managed or further escalated on numerous occasions. In 2013 a registrar raised a serious concern with the then Clinical Lead in Neurology about a pregnant woman having been diagnosed with epilepsy, and prescribed medication accordingly, when the evidence suggested she should not have been diagnosed. In the same year, another registrar went to the Clinical Director about various aspects of Dr Watt's practice, but the matter was not escalated or recorded. In 2015 the same registrar raised concerns with the Training Programme Director, but again the matter was not properly recorded and in the same year another registrar also gave evidence about raising a concern, albeit that there was confusion as to what had been said or communicated. The reasons for this are multi-factorial but include a failure on the part of those in clinical management to properly understand their role and the actions to be taken upon receipt of a concern.

31 Communication problems between those in primary care and those in secondary care were highlighted at the outset of the Inquiry. Some of the main themes that have been outlined in the Medical Culture chapter illustrate the difficulties faced by GPs in raising issues with consultant specialists. It was a matter of surprise that several GP witnesses disclosed that they were unaware of who to raise concerns with, and further alarming that attempts by GPs to raise concerns about Dr Watt floundered because of both reticence by the GP or ignorance by the person receiving the concern as to what should happen to the information. It is the case, however, that it was a GP, who ultimately raised the first series of index cases with the Medical Director's Office in November 2016, thus beginning the chain of events that led to the neurology patient recall in May 2018.

### The Complaints System:

32 A particular focus of this report is on the complaints system in place and the concerns that were raised but not further escalated or examined. The failure to learn from complaints was one of the more disturbing aspects of the investigation conducted by this Inquiry. Time after time, information was raised in a patient complaint, which needed to be independently investigated. Consistently the answer given to the complainant was obtuse and unhelpful.

33 The approach within Neurosciences was that, when a complaint was received from the Belfast Trust Complaints Department, the Service Manager or Assistant Service Manager would then seek the views of the clinician who was the subject of the complaint. In Dr Watt's case, his response was almost invariably to justify the



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that was less useless than I stated at the time.

318 Q. Maybe just a couple more questions. I've gone over the time that I said we were going to finish today.

A. That's okay.

319 Q. One of the things that you just said in answer, again I think to Mr. Hanbury, is that you disagreed with Mr. Haynes that consultants were the Trust or, may I put it this way, that you formed part of the Trust team? 15:21

A. Yes. 15:21

320 Q. So who, in your mind, is the Trust?

A. There's a good question, indeed. I think, you know, there requires to be some clear blue water between the clinicians on the one hand - even singular, the clinician. I mean you are the patient's advocate. 15:22

I regarded the arrangement best in the time of John Templeton being the Chief Executive, because he always said he was just a clerk whose job it was to facilitate doctors and nurses and other professionals 15:22 looking after as many people as possible who were in need of it. And I think that, you know -- it's been alleged I wasn't a team player. When I read that I wanted to ask well I wonder which team they're talking about, because I felt that I was a team player 15:22 very much with my colleagues, both medical and nursing. But was I a member of the Trust? Was I part of that team? I was to varying degrees. Was I part of management? No. Would I have ever been tempted to be

so? Absolutely not because it's not Aidan O'Brien.

So, who are the Trust? The Trust, actually, is a body that is a health service provider. There needs to be some distinction and autonomy and separation of function and accountabilities between whether it's the Commissioner and the Trust and the professional body below them. So there may be some overlap. I've never really been an advocate for clinicians continuing in clinical practice being senior managers. I think that you cannot have -- I think they just fooled themselves at the end of the day, even you're riding two horses at one time and sitting on the fence and you can't just do it. 15:23 15:23

321 Q. If I might tease that out little bit with you. Most doctors would prefer to be managed by their peers, by people who understand the job you have to do. So you would have a different view? 15:23

A. It depends, actually, what the management team is. You know, we had -- we had a small team. I was a lead clinician of the Urology MDT. So I played a management role. Our department had a lead clinician in Michael Young. I appointed, when I was lead clinician of the cancer MDT, Tony Glackin to be our governance lead in that role. So, yes, we can manage one another, but with regard to -- 15:24 15:24

322 Q. The line management.

A. Yeah. You can take that so far. I think that when you get up to Associate Medical Director - and I have seen

it too many times over the years - there may come a time for any individual in that role, where they have to toe the party line rather than the role that they used to do. And some people stepped down from that management role because they couldn't do so and others have toed the party line. So, I think I'm speaking a truth and I'm speaking it in moderate terms. 15:25

I preferred the situation where you went along with your shopping list and even though I got frustrated after a few years as to the productivity of it, I preferred there was an honest separation, go along, this is what we need, and whoever it was would say, well you're not getting it and we can't facilitate that and so forth. Now, whether there's some bridges across the water that's another matter and how they should be is another matter. But -- 15:25 15:26

323 Q. That's your view?

A. -- that's my view.

324 Q. And I know I have one further question and it's just in respect of MHPS, because we will be talking to you again, Mr. O'Brien. But just in respect of having been through this process, do you have any further reflections or suggestions that you'd like to make to the Inquiry, other than what we've already heard, about needing some greater support for the practitioner and an external person. I mean we've talked about whether you bring someone in externally who is there solely to carry out this MHPS process, to perhaps speed things 15:26 15:26

position weren't to hand within the hospital when another clinician may have required them?

A. No. I'm only smiling because I had never heard tell of incident report forms until a few years after that, when someone said to me that they had filled in an incident report. I thought it was something to do with the Inland Revenue and went and Googled it. I have never filled out myself. No, I didn't know about that.

232 Q. Again, a pattern is noted in how you deal with patient charts. If we bring up on the screen TRU-277892. In October 2014 -- just scroll between a little, please. Heather Trouton is asking Martina Corrigan: 16:27

"Are you aware that this issue of notes with Aidan O'Brien is still a problem? Has it improved at all". Up the page. "It had improved but I feel it may be slipping again and I will talk to Aidan again". 16:28

Was there, again, a pattern, rather like triage but perhaps for different reasons, of you complying with the request to get notes back and then falling into the difficulty for whatever reason of not getting them back or not getting them back quickly enough? 16:28

A. That wouldn't be my recall of it at all. I'm not denying that Martina may have spoken to me. I don't have any recall of any word with me about charts at home following any documented intent to do so. I don't recall it and I don't deny it. I just don't have any recall of it. 16:29

And I think the preface to that discussion might well have included a paper prepared by Mr. O'Brien in September of that year. So having put all of that information in front of you, what it seems to speak of in 2018 and then again in an SAI review published in the summer of 2020, is that the team, the Urology Service, is crying out for guidance by way of a policy or whatever, in terms of how triage is to be done, what's expected. And, secondly, a need to assess whether it's feasible to continue doing urologist of the week with triage within those responsibilities. Is that still the position? Is it still a concern?

14:22

14:23

A. It is still a concern. So I think I did write this document. It's not dated, and that's my fault that it is not dated. There are also handwritten notes which I think the Inquiry have access to. They're in my handwriting. And in this, as in all the sections of this document, what I'm trying to reflect is the nature of the discussion and the views expressed by the members of the team. They're not my personal views. As best as I could capture them, they are the views of the team.

14:23

14:23

So there was a variance of opinion as to how we should be dealing with is this. Mr. Haynes had one particular view, that we were responsible for sorting this out ourselves and that "we were the Trust", I think was the phrase he used. I think that that might have been

14:23

captured in a recording, which you may have the transcript to. Mr. O'Brien, Mr. Young and I didn't share Mr. Haynes view. We felt that it was incumbent on the Trust to provide a policy to clearly outline how this activity would be delivered, and we were therefore at variance with Mr. Haynes in that regard. 14:24

195 Q. So, I don't want to spend an awful lot of time on this, for obvious reasons, but just drilling down a little deeper. We have the debate as to whose responsibility it is to sort it out, but in terms of the team members, was there a divergence of view in terms of the doability of triage during the urologist of the week period? 14:24

A. Yes. Mr. O'Brien expressed the view at this meeting, and at other meetings, that he was struggling to do this activity in the time given. He also described how he was doing this activity in his own time. Whereas others, myself included, were able to deliver this activity within the allotted time. 14:24

196 Q. And is that, as I think you've alluded to already, is that divergence of views a reflection of a deeper divergence in terms of the approach to be taken to triage? In other words the time to be spent and the activity. You described it as a quasi clinic approach or words to that effect? 14:25

A. Yeah. So certainly I was not taking the approach that each patient needed a telephone consultation to work out what we were going to do. Mr. O'Brien expressed the view that he did that, that he spoke to lots of

time point if there is bleeding or if a little extra time is required to complete the procedure.

3.2 I am aware Mr O'Brien could on occasions perform TURP for more than an hour, however, I was not aware of the duration mentioned by Mr Hagan. It is likely that all Units will have examples of TUR Syndrome but I am not aware of Mr O'Brien having a higher incidence of TUR Syndrome than anyone else.

**(b) Do you recall this issue being raised with you by Mr Hagan? If so, please provide full details of all discussions with Mr Hagan.**

3.3 I do not recall a precise conversation on this case as it was 23 years ago, however, if Mr Hagan had raised an issue such as this I would have asked him had there been TUR Syndrome with this patient.

**(c) Do you recall responding to Mr Hagan in the manner he has suggested?**

3.4 With regards to the phrase "that's just Aidan", it is a phrase that I, as well as others, would have used in general terms. However, it certainly would not have been a phrase I would have used when responding to someone commenting upon a TURP of that duration.

**(d) To the extent that it is your evidence that you do not recall such interaction with Mr Hagan, please clarify whether it is your evidence that: (i) you do not recall any such interaction or (ii) that no such interaction occurred.**

3.5 I do not recall any such interaction regarding the TURP case that Mr Hagan has raised.



Received from Michael Young on 01/11/2023. Annotated by the Urology Services Inquiry.

the vast majority of them. The first 13 were to do with corporate governance at a point in time and, again, I think in fairness, Eileen, as Chair of the Trust, has really grasped those 13 now, but there was a period of time when that took a bit of debate for us to try and understand, and I think, you know, fair to say before Eileen arrived a realisation and acceptance that actually the corporate governance across the organisation needed to be strengthened, along with all of the other governance aspects that were there. 14:10 14:11

So I think that gave me a framework then in terms of improvement in relation to the overall corporate governance of the organisation and has, you know, been helpful to me in developing then the operational governance within the Trust. So we have concentrated on completely reforming the way we undertake corporate governance and, again, that has taken a lot of engagement, reflection, discussion, and we now have a revised corporate governance structure in place that brings patient safety and the quality of care very much into the minds of staff within the organisation, and feeds into the Governance Committee and sits alongside the Risk and Assurance Committee - or, sorry, the Risk Assurance and Audit Committee - that basically then quality assures some of that work that comes in. And then the other committees that are developed, the other five committees that are alongside that then are to support the overall approach to corporate governance. 14:11 14:11 14:12

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion

# PEOPLE & CULTURE GROUP
# TERMS OF REFERENCE

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| **VERSION** | 1.0 |
| **ASSURANCE** | **SECOND LINE ASSURANCE** |
| **PURPOSE** | The People & Culture Steering Group is part of the second line of assurance within the revised Integrated Governance and Assurance Framework. It will support the delivery of the Trust's Vision, Corporate Objectives and Priorities, identifying the gaps in controls and the constraints that prevent their achievement.<br><br>**Assurance**<br>The purpose of the People & Culture Steering Group (the Group) is to provide support to the Trust Strategy & Transformation Committee by obtaining assurance that:<br><br>• the Trust has plans with ambitious but realistic goals and targets relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives.<br>• the plans to achieve those goals and targets are being implemented.<br>• our people are reporting that our plans are making a difference to their working lives.<br><br>For example, they will initially oversee and support the implementation of the Trust's People Framework 2022-2025 to enable the Trust to achieve our ambition.<br><br>  <br><br>**Alerting**<br>The Group will alert the Trust Strategy & Transformation Committee where assurance cannot be given or further work or consideration is required by the Senior Leadership Team or at Committee Level.<br><br>**Advising**<br>The Group will advise the Strategy & Transformation Committee on matters within the scope of the Group's Terms of Reference.<br><br>**Accountability**<br>The Group is accountable to the Trust Strategy & Transformation Committee who in turn is accountable to the Trust Board. |
| **MEMBERSHIP** | Membership will initially consist of the Director of HROD, Deputy Director of HROD, 3 Executive Directors and Assistant Directors for the other directorates not represented.<br><br>**Chair: Director of Human Resources & Organisational Development** |



Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

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| | **Membership:**<br>• Vivienne Toal, Director of HROD<br>• Maxine Williamson, Deputy Director HROD, Workforce and OD<br>• Heather Trouton, Executive Director of Nursing & Midwifery and Allied Health Professionals<br>• Colm McCaffrey, Executive Director of Social Work<br>• Dr Stephen Austin, Medical Director<br>• Gerard Rocks, Assistant Director Promoting Wellbeing, ACS<br>• Dr Ivor Crothers, Clinical Director Psychology Services, MHD<br>• Lisa Houlihan, Assistant Director, MUSC<br>• Lynn Lappin, Assistant Director, SCS<br>• Dawn Livingstone, Assistant Director Performance Improvement, Planning, Performance & Informatics<br>• Sinead Rowe, Assistant Director – Finance, Procurement & Estates<br><br>**In attendance:**<br>The Chairs of each of the work streams will be in attendance. And any employee of the Trust may where appropriate, be invited to attend. The group may also decide to request individuals with specialist or expert knowledge to attend meetings. In these instances, the individuals will be co-opted for only those meetings at which the subjects on which they have expertise are to be discussed.<br><br>**Secretary:**<br>Organisational Development Practitioner<br><br>**Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.** |
| **DUTIES** | The People and Culture Steering Group will support the Strategy & Transformation Committee by maintaining an oversight of the 5 work-streams outlined below:- |



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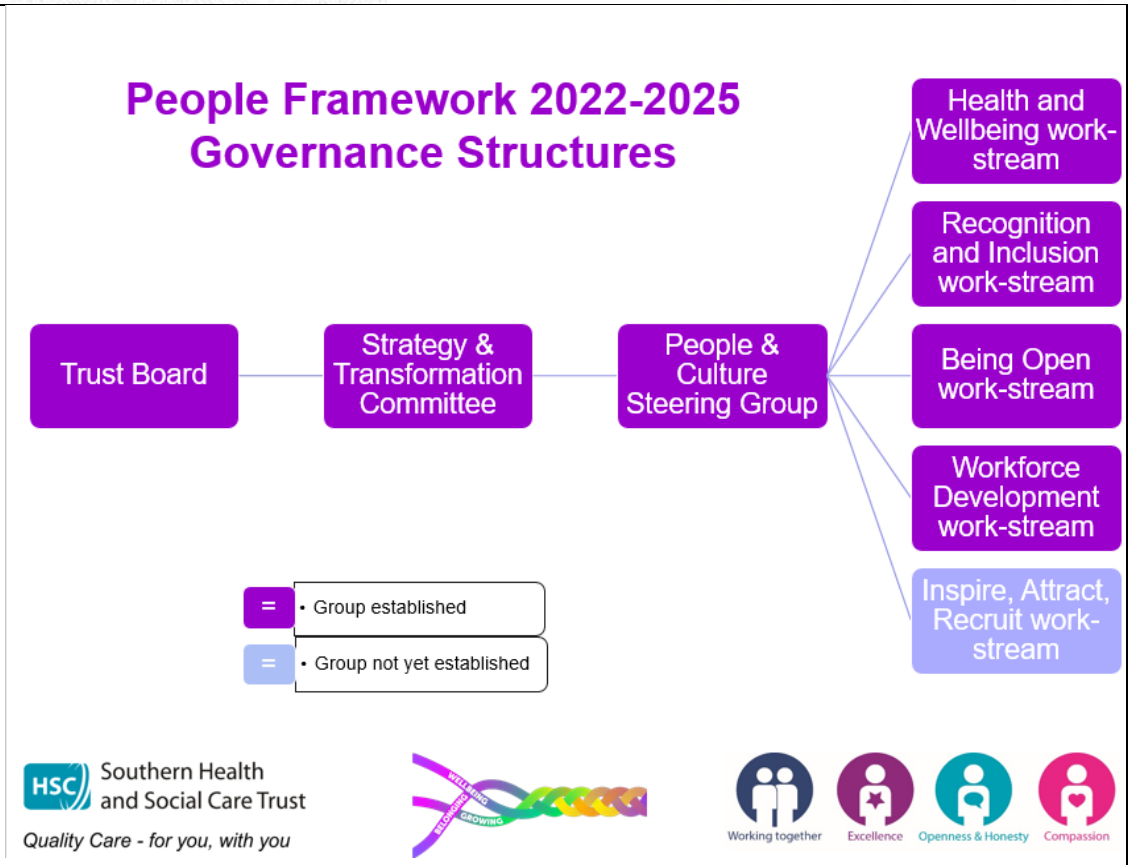


The People and Culture Steering Group will report to, and inform, the Integrated Governance and Assurance Framework as follows:

- Oversee development and monitoring of plans in relation to **Wellbeing** including:
    - Development and implementation of the Workplace Health & Wellbeing Framework 2022-2025 and associated annual action plan
    - Implementation of the recommendations of the Regional Review of Occupational Health & Wellbeing Services.

- Oversee development and monitoring of plans in relation to **Recognition and Inclusion** including:
    - Roll out of a programme of recognition including an calendar of national days of recognition and annual Trust Recognition Awards
    - Development of resources to support our team leaders and managers to recognise their people and their team(s).
    - Development and implementation of initiatives and training in relation to Equality, Diversity & Inclusion (EDI) that incorporates both our statutory obligations as well promoting inclusion and a sense of belonging



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| | • Oversee development and monitoring of plans in relation to **Being Open** including:<br>▪ Strengthening the organisational culture in accordance with the HSC values – Compassion, Openness & Honesty, Working Together and Excellence (including civility).<br>▪ Ensuring that our people feel psychologically safe to speak-up and able to raise suggestions or concerns including the development of an integrated plan encompassing Being Open; Freedom to Speak Up; and Restorative, Just and Learning Culture.<br><br>• Oversee development and monitoring of plans in relation to **Workforce Development** including:<br>▪ Vocational and professional workforce development: medical, non-medical, and non-clinical employees.<br>▪ Core leadership and management training<br>▪ Embedding a coaching culture including refreshing the Trust's Coaching Service and exploring future plans.<br><br>• Oversee development and monitoring of plans in relation to how we **attract and recruit staff** to our workforce and inspire the future generation of HSC staff including:<br>▪ Raising profile of the Trust as a great place to work, selling many of the benefits of working for us.<br>▪ Improve our attraction by deploying a mixture of communication channels to attract a broad and diverse audience to maximise our reach.<br>▪ Improving our workforce intelligence through greater understanding of our current workforce issues, supply and vacancy rate.<br>▪ Supporting recruiting managers by ensuring they have the necessary toolkits and support to recruit efficiently and effectively<br>▪ Improving the applicant experience by enhancing our recruitment systems and processes<br><br>• Review **risks** and mitigation related to the Trust's workforce and review reports or extracts from the Board Assurance Framework and Corporate Risk Register as relevant to the remit of the Committee. |
| **AUTHORITY** | The People and Culture Steering Group is authorised by the Strategy & Transformation Committee to undertake any activity within its Terms of Reference. |
| **MEETINGS** | **Quorum:**<br>A quorum for the meeting must include at least 60% of the members.<br><br>**Frequency of Meetings:**<br>The People & Culture Group will meet 4 times per annum and at least 1 – 2 weeks in advance of the Strategy & Transformation Committee. |



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| | **Papers:**<br>Agenda and papers will be disseminated electronically 5 working days before the date of the meeting.<br><br>**Meeting Arrangements:**<br>The group will meet face to face and only if necessary virtually via MS Teams.<br><br>**Withdrawal of individuals in attendance:**<br>During the course of a meeting, if a Conflict of Interest is established, the member concerned should withdraw from the discussion / meeting and play no part in the relevant discussion or decision. The Conflict of Interest should be recorded in the minutes.<br><br>Individuals invited for a specific item will be asked to withdraw following completion of that item. |
| **REPORTING** | The People and Culture Steering Group will advise and assist the Strategy & Transformation Committee in its work. The People and Culture Steering Group will report to Trust Board through the Strategy & Transformation Committee.<br><br>The People and Culture Steering Group, through its Chair and members, will work closely with the other Steering Groups within the Integrated Governance and Assurance Framework. The People and Culture Steering Group Chair will:<br><br>• Report formally, regularly and on a timely basis to the Strategy & Transformation Committee. This includes verbal updates on activity, the submission of minutes and written reports, as well as the presentation of annual reports from relevant areas as per the schedule of reports.<br>• Bring to Strategy & Transformation Committee's attention any significant matter under consideration of the People and Culture Steering Group.<br>• Ensure appropriate escalation arrangements are in place to alert the Executive Team, or Chairs of other relevant Committees / Steering Groups, of any urgent / critical matters that may compromise patient / client care and affect the operation and / or reputation of the Trust. |
| **CONFLICT/ DECLARATION OF INTEREST** | The Chair will seek and record any Declaration or Conflict of Interest from members prior to every meeting of the group. |
| **REVIEW** | These Terms of Reference and operating arrangements will be reviewed annually. |



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in 2019 by the (then) Chief Executive and Medical Director, each of whom was, at the time, relatively new to the Trust.

b. In 2019 the Trust began, and has since developed[6], its engagement with Mersey Care NHS Trust (a high-performing English Trust) to assist in developing a just and learning culture where staff, rather than feeling inhibited about 'speaking up' where they have concerns, are supported to do so[7].

c. In November 2022 the Trust set up an External Reference Group ('ERG'), chaired and populated by experienced people from outside the Trust (along with some senior Trust personnel) to provide the role of 'critical friend' to the Chief Executive and Directors in their work to address the shortcomings which the issues giving rise to the Inquiry have exposed[8].

d. The Trust has already initiated multiple improvements in its systems and structures of management, training, corporate governance, and clinical and social care governance in order to address the shortcomings within the Trust which were revealed by the Aidan O'Brien issues[9]. It has not sat back and waited for the Inquiry to tell it what to do.

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[6] By way of very brief non-comprehensive overview, this engagement began in 2019, with them delivering to the Trust presentations on an Open and Just Culture and their learning around a Zero Suicide Approach. The Trust HROD Director then underwent training with them on Restorative Just Culture in 2021, leading to the revision of Trust various Trust policies (e.g., disciplinary, conflict, bullying and harassment, and so on). Prof Joe Rafferty (CEO of Mersey Care from 2012) was the external representative when Dr O'Kane was appointed CEx in 2022 and has been carrying out a mentorship role since that time. In early 2023, this role expanded to 1:1 meetings with each Trust Director followed by a workshop and presentation to the Trust on his findings. Since then, work has included engagement by the Performance Director to assist with the Trust's strategy development work.

[7] See, e.g., Maria O'Kane's witness statement at WIT-45168 para 13 and WIT-45171 para 28 and her oral evidence at TRA-11652 Line 24 to TRA-11655 line 3, TRA-11669 lines 3-22, and TRA-11732 line 9 to TRA-11733 line 21. See also the evidence of Vivienne Toal at WIT-41009 para 1(iv) and TRA-03481 line 16 to TRA-03482 line 26.

[8] See, e.g., the evidence of Maria O'Kane at TRA-11632 to TRA-11646. An insight into the clear challenge function performed by this group is clear from the documents relevant to it disclosed by the Trust – see TRU-303646 to TRU-304283

[9] These are considered further in Chapters 4, 5, 6, and 7.



Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

# Local Trust Framework on Job Planning for Medical Managers

## Southern Health and Social Care Trust

**FINAL VERSION – Management document agreed by the Senior Management Team & Associate Medical Directors**

*This guidance document does not replace the Regional guidance on Job Planning but should be read as background information to be discussed between clinical manager and the Director within the Southern Health and Social Care Trust.*

*Please also refer also to:*

- *Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland*
- *SHSCT Medical Staff Annual Leave Guidance,*
- *NI Code of Conduct for Private Practice*
- *SHSCT procedural guidelines on the use of accommodation for private medical practice.*

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# Local Trust Framework for Job Planning

Southern Health and Social Care Trust

## 1.0 Direct Patient Care – Personal & Team Capacity – *Refer to Section 8 in Regional Guidance*

1.1 Prediction of an indicative number of fixed clinical PA's delivered per year will facilitate accurate capacity and workforce planning. A consultant job plan should deliver a predicable number of clinical PA's each year based upon agreed annual leave, study leave and professional leave allocations. There may be some individual variation, particularly for individuals with specific agreed responsibilities.

1.2 This information should be recorded clearly on the job planning template as part of individual and/or team job planning objectives.

1.3 The content of each Direct Clinical Care PA should be reviewed e.g. new patients per clinic, start and finish time and a time allocation for dictation/letter writing.

1.4 The number of fixed activities (such as outpatient clinics or theatre lists) appearing in a weekly job plan is multiplied by the number of weeks in the working year, 42 weeks to establish an indicative number of sessions per year, i.e. 52 weeks minus bank holidays, annual leave and study/professional leave.

1.5 Those responsible for scheduling PA's should note that any consultant wishing to complete their 42 weeks commitment (e.g. if 2 theatre PA's/wk = 84 theatre PA's/year) in *significantly* less time than the 42 working weeks may not be able to carry this out for the following reasons:

1.5.1 In order to carry out a DCC, a resource, usually involving other staff, will be required and it is unlikely that such resources will be available to accommodate a consultant wishing to work their annual commitment in a short time.

1.5.2 On a full time contract with DCCs and SPA's, the only way to work an annual commitment in less than the agreed weeks would be to exceed the EWTD.

1.5.3 The idea behind these changes to the job plan are to spread out the work evenly across the year to the mutual benefit of both the Trust and the consultants, resulting in a safer environment for patients and a healthy life/work balance for the consultants.

1.5.4 If the AMD / CD feel that a service will be better supported/delivered through such an arrangement, then such flexibility may be agreed in these circumstances.

1.6 An example of building in capacity into job plans would be as follows: if there are 3 PA's of outpatient clinics, per week on the job plan, then the indicative annual clinic contribution should be 3 x 42 = 126 expected clinics per year. If clinics have been cancelled for reasons of SPA (educational events or urgent meetings), then replacement clinics should take place in designated time which was previously SPA time or time off.

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1.7 The inclusion of an indicative number of sessions per year in a job plan is to facilitate better capacity and workforce planning. Where a consultant does not deliver the expected number of sessions per year for reasons outside their control, the Trust will not use this as criteria for deferring pay progression. For example, factors which may affect this could include the impact of sick leave, planned or unplanned. These issues should be discussed and agreed at job planning.

## 2.0 Direct Patient Care - Productivity

2.1 For outpatient clinics and operating theatre sessions, an indicative estimate of the number of patients per fixed clinical PA should be included in the job plan template under individual/team job plan objectives. Justification will be from agreed levels of service for clinic and theatre capacity or from retrospective data including new to follow up ratio.

2.2 A clinical manager can use national norms or accepted best practice to determine/alter new and review ratios. Clinicians will be encouraged to find new ways to discharge/review patients e.g. telephone reviews, letters to patients or GP's agreeing primary care follow-up etc.

2.3 An individual's or teams' capacity should be agreed with clinical teams and signed off by the divisional management. Issues which are outside the control of the consultant must be discussed and recorded at job planning. This might include the impact of sick leave, planned or unplanned and the impact of any significant deficiencies in supporting infrastructure.

## 3.0 Direct Patient Care – Additional Points

3.1 In all instances, consultants and clinical managers should ensure there is no double counting of time within job plans. One example of this might be where a consultant is undertaking teaching whilst in an outpatient clinic such activity should only be counted once for programmed activity purposes. The clinical manager and the consultant should agree the appropriate split between DCC and SPA.

3.2 It is the Trust's intention that job planning should work towards no consultant being contracted to work more than an average total of 48 hours in order that the Southern Trust fulfils its responsibilities regarding standards set out in the European Working Time Directive. In practice this normally translates to a 10 + 2 PA contract - if the additional PA's are paid for actual working time and not responsibility payments.

3.3 Direct patient care should generally comprise:

3.3.1 Depending on agreed SPA's and Clinical Administration; normally between 6.5 -7.5 PA's (26-30 hours) for Patient related activities including ward rounds, theatre lists, procedure lists, MDT meetings, consultations, outpatient clinics, emergency reviews and labour ward. Within the 1PA allocated to an outpatient clinic, it would be expected this would include an agreed time allocation of direct patient contact with time allowed for immediate letter writing /dictation in specialties where this is customary.

3.3.2 An agreed PA allocation for Clinical Administration e.g. letters, review of results, discussions with GP's and relatives.

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## 4.0 Team Job Planning – *Refer to Section 4 in Regional Guidance*

4.1 The presence of a team job plan is entirely acceptable so long as each individual agrees to participate without coercion and that they still retain the right to sign an individual job plan agreement with the Trust.

4.2 The total workload (DCC, SPA, On-call) for a group of consultants should be estimated and then each element factored into individual job plans. The principal of team job planning is that all DCC and SPA activity is seen as shared and collective responsibility.

4.3 The following should be considered when developing a team job plan:

4.3.1 Determine what direct patient care activities are required to deliver the service.

4.3.2 Identify the number of consultant hours required to deliver each activity

4.3.3 Determine the number of weeks in the year when each activity occurs (e.g. 42)

4.3.4 Determine the annualized hours for each activity (based on point 4.2.1 & 4.2.3)

4.3.5 Quantify how many consultants are available week to week to deliver the service (taking account of absences for annual/study leave)

4.3.6 Divide the annualized hours by the figure identified in 4.2.5 to determine the average DCC working week per full time consultant

4.3.7 Quantify the total SPA commitment as well as any additional duties (e.g. Additional Responsibilities/External Duties) across the team.

4.3.8 Add the figures identified in 4.2.6 and 4.2.7 together to determine the total weekly PA figure. If this figure lies outside 10 PA's basic contract, discussions will be needed about how to manage the gap – e.g. additional Programmed activities, consultant expansion, new ways of working.

4.3.9 Individuals within the team should have personalized job plans based on their individual commitments. It would be good practice that the team agree and sign a statement about how they work as a team defining their shared objectives. Where objectives are team based, the role of each individual consultant needs to be clear.

4.4 Please refer to the Appendix Section for a working example of team job planning.

## 5.0 Annualised Job Planning – *Refer to Section 15 in Regional Guidance*

5.1 There may be some consultants who have activities that do not fall on a regular weekly basis and therefore do not lend themselves to preparing a weekly job plan. Therefore it will be necessary to have an element of their job plan annualized. However, the principles of job planning remain unchanged.

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5.2 Where a consultant undertakes irregular clinics or additional roles, this will need to be annualized. For example, if a consultant has been approved to take on an examining role (EPA's) which will involve approximately 5 days per year – this is annualized as follows: 5 full days per year equate to 40 hours/yr, or 10 programmed activities. 10 PA's divided by 52 weeks = 0.19 PA per week. (No prospective cover).

## 6.0 On-call Activity

6.1 Allocations for unpredictable emergency work must be evidenced by a diary data on a team basis. For example:

6.1.1 A diary analysis indicates 37 hours of unpredictable on-call activity worked by the team in 1 week.

6.1.2 37 hours / 3 = 12.3 PA's of unpredictable on-call activity per week for the team

6.1.3 To allow for prospective cover – 12.3 x 52 weeks / 42 working weeks = 14.5 PA's

6.1.4 This must be divided by the number of consultants on the on-call rota e.g. 16 consultants on rota = 0.91 PA each for on-call.

6.1.5 Therefore if a consultant team was offered 0.91 PA for unpredictable on-call, this equates to approximately 37 hours. It is useful to ask if this represents the actual workload. If not, a re-diary card exercise may need to be undertaken.

6.2 **Change to workload/New Appointment** - It is essential that if there has been a change to the workload or following a new consultant appointment, the unpredictable on-call activity for the team must be reviewed and changes notified appropriately.

6.3 **Frequency of the on-call rota** – If there has been a change to the on-call frequency e.g. High frequency (1 in 1 to 1 in 4); Medium frequency (1 in 5 to 1 in 8); Low frequency (1in9 or less frequent) which takes it from one category to another, a notification (Proforma attached) of this change must be completed.

6.4 **Predictable On-call** - should be agreed in advance (e.g. weekend ward rounds or fixed operating which are scheduled and include other resources i.e. nursing/other clinicians joining the activity.) Time allocated should be on the basis of the number and complexity of the activities or sound diary exercise to account for the time allocation. The above calculation to include prospective cover can also be included.

**Method for calculating on-call**

| | |
|---|---|
| 1 | Determine the total number of emergency out of hours worked by the team of consultants, identified via a diary card exercise. |
| 2 | Divide the total hours by three to determine premium time PA's |
| 3 | Multiply by 52 weeks per year |
| 4 | Divide by 42 working weeks per year (as this includes prospective cover) |
| 5 | Divide the weekly PA's by the number of consultants working on the on-call rota |
| 6 | This weekly PA figure will represent the on-call to be allocated to each consultant. |

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

## 7.0 Supporting Professional Activities – *Refer to Section 9 in Regional Guidance*

7.1 ***Please refer to further guidance on Supporting Professional Activities in Appendix Section***

7.2 A minimum of 1.5 PA's for supporting professional activities should be allocated to all consultants and considered as the minimum time resource for maintaining a professional career. This allocation will be the same for full and part time consultants. This allocation will require evidence of full participation in mandatory training programmes evidenced at appraisal and copies available for the Job Plan meeting. Evidence of CPD must also be presented at appraisal.

7.3 This SPA activity should include as a minimum CPD outside study /professional leave, requirements for licensing & recertification and mandatory training, appraisal and job planning, basic teaching, training and supervision of junior staff, administration related to these duties and attendance at audit meetings and clinical governance activity to meet minimum standards required i.e. average 1 hour per week.

7.4 Additional SPA allocation over 1.5 must be evidenced and timetabled into the job plan and agreed by the Clinical Director/Associate Medical Director. It is expected that this additional activity would deliver quality improvements and align with Trust objectives.

7.5 It is expected that SPA's should normally be worked onsite. Clinical Managers should work to ensure adequate space/facilities are available to encourage protected time for all consultants.

7.6 Any clinical activity lost due to scheduled SPA (e.g. the rolling governance programme) should be re-provided flexibly at a time agreed by the consultant and clinical manager. Where this is not possible, this should be discussed with the clinical manager and service director.

7.7 Clinical managers should be careful to ensure that SPA's are evenly divided between members of a team and that individual SPA's do not rise year on year.

## 8.0 Travel Time

8.1 Travelling time between a consultant's main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.

8.2 Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).

8.3 All regular travel times to external sites from base hospital should be included in the job plan using the current suggested travel times (See Appendix Section for SHSCT Travel Time Chart)

8.4 Job Plans should be designed to minimize disruption of fixed clinical episodes by time spent traveling between sites e.g. arranging for a full day in one clinical area rather than movement between site A&B during the day.

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8.5 Travel to and from work for HPSS emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.

8.6 **Working Example** - If a consultant normally takes 45 minutes to travel from their base hospital (e.g. CAH) to an outlying clinic (e.g. DHH) and a consultant doesn't travel to base but goes straight from home to the outlying clinic, then they can claim for "excess time" in their job plan if it takes them longer to travel from home. Therefore if consultant X lives in Belfast and it takes them 1 hour to travel to DHH, then they could claim 15 minutes in their job plan. However if they lived further away and it took them 1.5 hours to travel to DHH straight from home (or they had to come to base first for clinical reasons) then they would claim 45 minutes in their job plan.

## 9.0 External Duties & Additional HPSS Responsibilities – *Refer to Sections 10 and 11 in Regional Guidance.*

9.1 **External Duties** - The Trust would seek to facilitate consultants wherever possible for such work that is not directly for the Trust but is relevant to and in the interests of the wider HPSS. External duties should normally be connected to activities relevant to clinical medicine.

9.1.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.

9.1.2 Consultants must have approval from their Associate Medical Director before accepting external duties. Service Directors must also been involved and advised of the commitment and its impact on delivering the job plan The timing and duration of the role and an indication on whether the role is funded externally MUST accompany this request.

9.1.3 Where possible all external HPSS duties MUST be included within the job plan with a clear time allocation and set within an agreed timeframe with a specific end date. It may be necessary to annualize due to the nature/irregular timing of the work.

9.1.4 Clinical managers should seek to spread this work equitably across consultant teams and the Trust where possible. Any agreement should acknowledge the importance of the priority of consultants' commitments to direct clinical care and supporting professional activities. Measurable objectives for External Duties MUST be discussed, agreed and be clearly specified on the job plan template.

9.1.5 Facilitating consultants for external duties must be governed by the need to retain a balance between different elements of the job plan in a way that maintains the required delivery of services to patients in terms of both activity and quality. It is reasonable for the clinical manager to seek to secure/maintain required direct clinical care commitments.

9.1.6 Clinical Managers must keep detailed records of external commitments and provide an annual report of such commitments to the Medical Director and the Senior Management Team in the Trust.

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

9.1.7 External duties that do not contribute to the interests of the HPSS should either be carried out during professional or study leave or where the consultant so chooses, during his/her annual leave.

9.2 **Additional HPSS Responsibilities** – These are activities agreed between a consultant and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA's e.g. Clinical Director, Clinical Tutor, Regional Education Advisor etc

9.2.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.

9.2.2 Where a clinical director post becomes available, the Trust will undertake an internal appointment process. This will set out the nature of the role including time/PA allocation and the terms and conditions associated.

9.2.3 Each clinical manager needs to be aware of the roles of the consultant and how the roles are funded to ensure appropriate job planning. In some cases the allocation will vary among specialties, depending upon the required commitment and in some circumstances (e.g. Clinical Tutors), the number of junior doctors. Further guidance and support should be sought regarding teaching roles, their time commitments and job planning for them.

9.2.4 An appropriate PA allocation for Additional HPSS Responsibilities should be agreed between the clinical manager and the individual consultant and included on the job plan template.

## 10.0Job Planning Objectives – *Refer to section 3 in Regional Guidance*

10.1 Job Plan Objectives are an essential part of the new consultant contract (Schedule 3 paragraph 10). These should be set out in the job plan and tailored to reflect local service development plans and priorities.

10.2 Objectives should state specifically what an individual consultant (or team) will be expected to deliver and how these objectives will be measured on an annual basis. It is recommended that the SMART framework is adopted. (i.e. Specific, Measurable, Achievable, Relevant, Timed and tracked.)

10.3 Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreed by the consultant and his/her clinical manager. The consultant and his/her clinical manager should use job planning to identify resources that are likely to be needed to help the consultant carry out his/her job plan commitments over the year and achieve his/her agreed objectives for that year.

10.4 Sample Objectives may incorporate the following: waiting list targets, quality of service as measured by PFA targets to balance capacity and demand, safer patient issues arising from patient safety issues, professional standards, lessons' learned from national, regional and local incidents & CHKS information.

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10.5 Examples of "Hard Objectives" in relation to direct patient care should include the indicative capacity/productivity information discussed and agreed e.g. "Annual clinic contribution will be 126 expected clinics per year" (where there are 3 PA's of outpatient clinics per week in a job plan) Or "Annual operating theatre contribution will be 84 expected theatre PA's per year" (where there are 2PA's of theatre PA's per week in a job plan).

## 11.0 Private Practice – *Refer to Section 13 in Regional Guidance*

11.1 Regular work for other providers should be identified on the job plan indicating time and location. Such work should not occur in remunerated direct patient care or SPA time contracted to the Trust. It is the responsibility of the Clinical Director and the Consultant to ensure there is no double counting of time.

11.2 All consultants are expected to conform to the Northern Ireland Code of Conduct for Private Practice and the handbook concerning the management of private practice in Health Service Hospitals in Northern Ireland. In addition to these documents, it is also important to note that any private practice done when on-call should not prevent immediate return to the hospital to attend emergencies if required.

11.3 Consultants should also refer to the Southern Trust procedural guidelines on the use of accommodation for private medical practice.

11.4 The notification of private patients using the agreed paperwork e.g. PP1, PP4 and undertaking to pay forms should be agreed.

11.5 If a consultant undertakes regular Domiciliary visits then this should be allocated time in his/her job plan and no fee will be paid other than travel expenses.

11.6 If a consultant undertakes occasional domiciliary visits outside his/her job plan, he or she may claim the appropriate fee and travel expenses.

11.7 Family Planning fees are not paid for by SHSCT to consultants or non training grades.

## 12.0Overarching Principles

12.1 Work outside of the contracted job plan will be reimbursed in a way that is mutually agreeable between the Chief Executive and the individual consultant. Please refer to further guidance in relation to payment of waiting list initiative payments, which has been agreed with the Local Negotiating Committee.

12.2 Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty. See Job Planning Flowchart in the Appendix Section.

## 13.0 Job Planning Timeline

See Appendix Section for Job Planning Summary and Timeline

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# Local Trust Framework for Job Planning

## Final

Author Zoe Parks: Head of Medical Staffing

Approved by Southern Trust Local Negotiating Committee of the BMA – March 2019



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# Local Trust Framework for Job Planning

## CONTENTS





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## 1. BACKGROUND & PRINCIPLES

- In 2004 the new consultant contract introduced a new and more robust system of job planning, which was also included in the new Speicalty Doctor and Associate Specialist contracts. The purpose of this local guide is to set out the Trust's approach to Job planning. The guidance also takes account of the introduction of an Allocate electronic Job Planning system.

- This document does not amend, discard or move away from national contracts, terms and conditions. It provides a framework for Job Planning to ensure consistency across the Trust. Please also refer to:

    - Department of Health Terms and Conditions of Service: Link Here
    - Consultant Job Planning – A Best Practice Guide July 2017 NHS Improvement July 2017 Guide
    - Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland April 2008: DOH Regional Guide April 2008 and the other associated documents
    - Regional Guidance on Job Planning for Medical & Dental SAS & AS Doctors in Northern Ireland: DOH Regional Guidance on Job Planning for SAS and Associate Specialist Doctors
    - Zircadian/Allocate Guide to E Job planning - Guide for Doctors & E Job planning Guide for Managers
    - SHSCT Medical Staff Annual Leave Guidance

- Job planning is a contractual requirement for consultants/SAS Doctors and employers.

- Directorate management teams and the consultants/SAS Doctors should approach the Job Planning process with professionalism, honesty, openness and accountability on all parts.

- The job planning process is prospective; therefore decisions made, will affect future work and payments. A prospective commencement date must be stated on the e-job plan.

- Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty.

- All Job Plans over 12 PA's will be reviewed by the Senior Management Team periodically to ensure they are not out-with EWTD legislation. All doctors must ensure they comply with their responsibilities under this legislation to safeguard safe weekly working hours. This includes all hours worked in private practice and/or the independent sector.

## 2. JOB PLANNING CONSISTENCY COMMITTEE

2.1 To promote and facilitate Best Practice, A Job Planning Consistency Committee will be established to ensure job planning is consistent between specialties and across the Trust. The role of this group will be to provide assurance that job planning is in line with regional and Trust guidelines. It is anticipated this will be led by the Medical Director (or deputy) and involve input from the medical and service managers. A summary report will also be issued to BMA LNC annually. This group will review practices and suggest changes to help improve the job planning process on a prospective basis for the following year, with any changes being agreed through LNC.



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## 3. ROLES & RESPONSIBILITIES

### 3.1 Clinical Directors and/or Associate Medical Directors

- Agree with directorate management demand and capacity for the specialty, shape of current service, aspirations of the service, must do's (clinical governance, local SABA requirements) etc.
- Clearly identify through job planning how the Trust's activity targets can be met. They should identify and commission any additional activity needed, or identify how to replace direct clinical care no longer required.
- Consider need for diary of on-call activity if numbers or activity levels have changed.
- Conduct effective job planning meetings
- Agree final job plan with individual doctor for the year and ensure it has been entered on the electronic job planning system in line with expected timescales. See Job Planning Cycle (section 4) for proposed timescales.
- Ensure all new starts have a job plan approved and signed within the first **three months** following commencement.
- Ensure a speedy response to all requests for interim job plan reviews
- Ensure all job plans are reviewed on an annual basis
- When necessary take part in the facilitation and appeals process.

### 3.2 Individual Doctors

- Participate in job planning and ensure it sets out all of their HSC duties and responsibilities, objectives and service to be provided.
- Participate in your job plan review with your Clinical Director/Associate Medical Director at least on an annual basis.
- Request an interim job plan review when your duties, responsibilities, accountability arrangements or objectives have changed or need to change significantly within the year.
- Enter your job plan onto the electronic job planning system within the Trust
- Request facilitation (via the medical director) when the annual job planning meeting with your Clinical Director/Associate Medical Director has not reached agreement

### 3.3 Service Directors

- Each Director will have accountability for ensuring all Consultant and SAS doctors have an agreed job plan on an annual basis within their Programme of Care.
- Support Clinical Directors and Associate Medical Directors in discharging their job planning responsibilities.
- Ensure that each doctor has the facilities, training, development and support needed to deliver the commitment in their agreed job plan
- Ensure all the relevant service information is provided to Clinical Directors and Associate Medical Directors on a timely basis for the year ahead so this can be factored into job plans – see timescales on Job Planning cycle (section 4).
- Sign off electronic job plans in a timely manner. If either party feels there is undue delay – they should contact the Head of Medical HR so timeframes can be reviewed.

### 3.4 Medical Director

- Be available to give advice and support as necessary
- Undertake job planning for the Associate Medical Directors
- Take a leading role in the facilitation and appeals process
- Promote and encourage consistency within job planning across the Trust
- Consider the need for establishing a Job Planning Consistency Committee as and when required to steer best practice.



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**3.5 Medical HR Department**

- Provide general support and guidance in all aspects of the job planning process
- Ensure the electronic job planning system remains updated and fit for purpose
- Assist with compiling reports and summary job planning information as required.
- Notifying all changes to Programmed activities to the Payroll Department following notification of an approved signed job plan.
- Liaise with Allocate regarding any system related difficulties or update

## 4. JOB PLANNING CYCLE

- Job planning is an annual requirement for all consultants and SAS doctors within the Southern Trust. Job Plans that worked this year may not work next year. Whilst some doctors continue to work the same pattern every week, changing patterns of service delivery and doctor preferences increasingly demand variable patterns from week to week or part/fully annualised job plans.

- Job plans may need to be reviewed in year in response to activity changes, following new appointments or organisation change. Where this is necessary the Clinical Director or Medical Staffing HR Manager should "republish" the electronic job plan so that it can be edited by the clinical manager and/or consultant. The normal job planning process can then take place.

- To ensure all doctors have an approved job plan by 1 April each year; the following job planning cycle is proposed within the Southern Trust.

***See following Page for Southern Trust Job Planning Cycle***



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# Job Planning Rounds
## Target Dates & Timescales

| | |
|---|---|
| **Quarter 2** | |
| July – September | Clinical Director prepares for next job planning round.<br>Clinical Director considers if there is a need to undertake updated on-call diary. Clarify with Finance, what external funding may be available for the following year.<br>Send early notification to consultants/SAS Doctors that new job planning Round due to commence for start date the following April. |
| **Quarter 3** | |
| October – December<br><br>*Electronic reminders will be sent from the E Job planning system to reflect these target expectations.* | **Month of October:**<br>Team specialty meeting to discuss; job planning requirements, team objectives, allocation of specific SPA's or additional roles and any required rota changes for the following year etc.<br><br>***1st November***: All job plans within the E Job planning system will be Locked Down centrally and republished to allow consultants to edit individual job plans.<br><br>**November/December:** Individual Job Plan meetings to take place.<br><br>**By 31 December:** All Job plans should be entered on electronic system and the electronic sign off process commenced. Where it has not been possible to agree a prospective job plan; a request for facilitation should be made to the Medical Director by the consultant or clinical manager. This should also be recorded on the e job planning system.<br><br>**January:** A Job planning Consistency Committee to be convened to review a sample of agreed job plans to ensure consistency across clinical areas. |
| **Quarter 4** | |
| January to March the following year<br><br>*Electronic reminders will be sent from the E Job planning system to reflect these target expectations.* | E Job plans progress through the sign off levels to ensure a fully signed off job plan achieved for 1 April. Facilitation meetings and Appeals to be arranged during this time where necessary to ensure agreements made for 1 April. |
| **Quarter 1** | |
| April to June the following year | Job plan effective 1 April |

- *New Doctors should have a Job plan Review **within 3 months** of commencing in post.*



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## 5. JOB PLANNING AND LINK TO PAY THRESHOLDS

5.1 Schedule 15 sets out the link between Pay Threshold and the Job planning process.

5.2 Consultants and SAS doctors must engage with the job planning process to ensure pay progression. Where it is not possible to agree a job plan; consultants should invoke/engage with the facilitation and appeal process, as this constitutes engagement for the purposes of pay progression.

## 6. ELECTRONIC JOB PLANNING SYSTEM

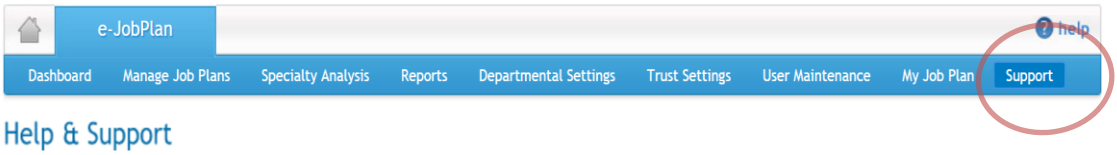
6.1 The e-Job Plan system is web based and can be assessed from any internet ready PC, MAC, smart phone or tablet (iPad) using the following link: www.healthmedics.allocatehealthsuite.com

6.2 Each consultant/SAS Doctor will be issued with a username and password to access the system. If doctors forget or lose their access details, there is a forgotten password link on the e-Job Plan homepage or you can contact the Medical Staffing HR Department who can reset or reissue these details.

6.3 The Trust is keen to retain the Job planning meeting between consultants/SAS Doctors and Clinical Directors. However, there is the facility for a virtual electronic job plan meeting subject to the agreement of both parties.

Training can be provided by the Medical HR Team however there are also user guides available for e Job planning systemZircadian/Allocate Guide to E Job planning - Guide for Doctors & E Job planning Guide for Managers

6.4 If a doctor is having trouble creating a job plan, Medical Staffing/HR will provide individual support using the online job plan wizard demo which allows you to familiarise yourself with how to create a job plan without saving or storing any data. - Link to Wizard Demo




Help & Support

6.5 Doctors are reminded to ensure they update their **preferences** to ensure they receive the appropriate email notifications that they wish to receive about their job plan. This is located at the top left of the screen when logged into the electronic job planning system.


6.6 When in the E Job Planning system - avoid clicking on the **Home** button as this will return you to Allocate Software Homepage. Use the **back button** or click on the blue menu bar to avoid this. If you do not have a management role, please be aware that your blue menu bar will only show the options for "My Job Plan" or "Support".



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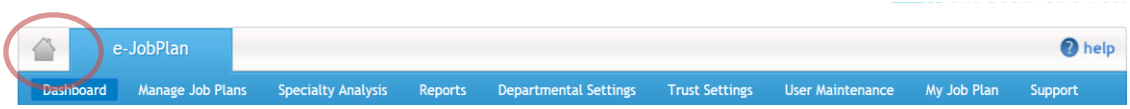


6.7 Details of the terminology used throughout the E-Job plan system as well as the calculation used in the on-call and routine work sections of the job plan are available to view online - Link here



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## 7. KEY ELEMENTS OF JOB PLAN

7.1 Job plans should contain an agreed baseline of commitments detailing attendance and activity expectations for the year ahead. These should be transparently reviewed and agreed, and be clearly documented for future reference. Activity expectations should be based on a minimum of 41- 42 weeks in the working year. A job plan covers the whole of the week, including – where relevant weekends and nights (to ensure consistent delivery of high quality patient care) and takes account of all flexible working arrangements.

7.2 Key elements in a job plan are:

- Objectives
- Direct clinical care
- On-call and emergency work
- Supporting professional activities such as clinical audit participation, case note review and other activities relevant to the individual's revalidation
- Additional responsibilities and duties
- External duties
- Private professional services
- Fee-paying services
- Travel time
- Supporting resources

## 8. JOB PLAN OBJECTIVES

8.1 The job plan must help achieve service business plans and the Trust's organisational objectives. This is recognised and documented by NHS Improvement in their document "Consultant Job Planning a Best Practice Guide 2017". This can be achieved by incorporating meaningful job plan objectives within individual and team job plans (see section 9 for team job planning).

8.2 Objectives should be based on the latest evidence, subject to benchmarking where possible and designed to eliminate or reduce variation. Starting with objectives is the key to aligning consultants and employers, and makes it easier to review and adjust job plans. Translating the Trust's objectives into meaningful, measurable objectives in job plans allows consultants to identify changes required to support growth and efficiency in their service and ensure it remains attractive to commissioners.

8.3 You should agree objectives in 'SMART' form – that is, they should be:

S specific
M measurable
A achievable
R realistic
T timed

8.4 Job planning Objectives can take the form of a prediction of an indicative number of fixed clinical PA's delivered per year to help align service delivery plans and inform workforce planning. The prediction of clinical PA's expected each year should consider agreed annual leave, study leave and professional leave allocations. There may be some individual variation, particularly for individuals with specific agreed responsibilities.



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8.5 The number of fixed activities (such as outpatient clinics or theatre lists) appearing in a weekly job plan is multiplied by the number of weeks in the working year (normally 42 weeks) to establish an indicative number of sessions per year, i.e. 52 weeks minus bank holidays, annual leave and study/professional leave. For example; if there are 3 PA's of outpatient clinics per week on the job plan, then the indicative annual clinic contribution should be 3 x annual working week (normally 42) = 126 expected clinics per year.

8.6 The objectives may also include an indicative estimate of activity within a session for example number of new/review patients per clinic, start and finish time and a time allocation for dictation/letter writing (if necessary). A clinical manager should use benchmarked national norms or accepted best practice to determine/alter new and review ratios. Clinicians will be encouraged to find new ways to discharge/review patients e.g. virtual clinics, telephone reviews, letters to patients or GP's agreeing primary care follow-up etc. This should be discussed with consultants at the outset of the job planning stage – e.g. at the team specialty meeting to prepare for the prospective job planning round.

8.7 Those responsible for scheduling PA's should note that any consultant/SAS Doctor wishing to complete their annual weeks commitment (e.g. if 2 theatre PA's/wk = 84 theatre PA's/year) in less time than the normal 42 working weeks may not be able to carry this out for the following reasons:

- *In order to carry out a DCC, a resource, usually involving other staff, will be required and it is unlikely that such resources will be available to accommodate a consultant/SAS Doctor wishing to work their annual commitment in a short time.*
- *On a full time contract with DCCs and SPA's, the only way to work an annual commitment in less than the agreed weeks would be to exceed the EWTD.*
- *The idea behind these changes to the job plan are to spread out the work evenly across the year to the mutual benefit of both the Trust and the consultants, resulting in a safer environment for patients and a healthy life/work balance for the consultants.*

If the AMD / CD feel that a service will be better supported/delivered through such an arrangement, then such flexibility may be agreed in these circumstances.

8.8 One of the criteria as set out in Schedule 15 which determines if pay thresholds can be awarded relates to meeting Personal Job Plan Objectives. Where a consultant/SAS Doctor does not meet personal objectives for reasons outside their control, the Trust will not use this as criteria for deferring pay progression. For example, factors which may affect this could include the impact of sick leave, planned or unplanned. These issues should be discussed and agreed at job planning.

## JOB PLANNING – GENERAL POINTS

8.9 In all instances, consultants/SAS Doctors and clinical managers should ensure there is no double counting of time within job plans. One example of this might be where a doctor is undertaking teaching whilst in an outpatient clinic such activity should only be counted once for programmed activity purposes. The clinical manager and the doctor should agree the appropriate split between DCC and SPA.

8.10 It is the Trust's intention that job planning should work towards no doctor being contracted to work more than an average total of 48 hours in order that the Southern Trust fulfils its responsibilities regarding standards set out in the European Working Time Directive. In practice this normally translates to a 10 + 2 PA contract.



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8.11 Clinical Managers may request medical staff to work more than 10 PAs per week or to take on additional responsibilities. If so, the consultant and the clinical director or manager must agree the additional PAs or responsibility allowance. Additional PAs should be reviewed annually as part of the job plan review. However both parties can end the agreement outside the job planning review with three months' notice. Additional programmed activities should normally be for direct clinical care work unless specifically agreed with the Trust during job planning.

8.12 Direct clinical care is work directly relating to the prevention, diagnosis or treatment of illness, i.e. clinical, clinically related activity including patient administration. The consultant's schedule of PAs should clearly describe the type of direct clinical care activity, as well as when and where it is undertaken. For full time DCC Allocation should normally be between 6.5-7.5 PA's (26-30hours) and include all patient related activities such as ward round, theatre lists, procedure lists, MDT meetings, consultations, outpatient clinics, emergency reviews, labour ward and patient administration.

## 9. TEAM JOB PLANNING

9.1 The presence of a team job plan is entirely acceptable so long as each individual agrees to participate without coercion and also have an individual job plan.

9.2 The total workload (DCC, SPA, On-call) for a group of consultants/SAS Doctors should be estimated and then each element factored into individual job plans. The principal of team job planning is that all DCC and SPA activity is seen as shared and collective responsibility.

9.3 The following should be considered when developing a team job plan:

- Determine what direct patient care activities are required to deliver the service.
- Identify the number of consultant hours required to deliver each activity.
- Determine the number of weeks in the year when each activity occurs. (e.g. 42)
- Determine the annualized hours for each activity.
- Quantify how many consultants/SAS Doctors are available week to week to deliver the service (taking account of absences for annual/study leave).
- Divide the annualized hours by the number of consultants/SAS Doctors available to determine the average DCC working week per full time consultant.
- Quantify the total SPA commitment as well as any additional duties (e.g. Additional Responsibilities/External Duties) across the team.
- Determine the total weekly PA figure. If this figure lies outside 10 PA's basic contract, discussions will be needed about how to manage the gap – e.g. additional Programmed activities, consultant expansion, new ways of working.

9.4 Individuals within the team should have personalized job plans based on their individual commitments. It would be good practice that the team agree and sign a statement about how they work as a team defining their shared objectives. Where objectives are team based, the role of each individual consultant needs to be clear. This should include details of shared objectives and responsibilities and will ensure joint ownership and shared responsibility for success of the team plan.

9.5 If you are considering a team Job Planning approach – you should refer to the regional documentation (listed in the introduction section) for more guidance on devising these job plans effectively. The Medical HR Department can also assist where necessary.



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## 10. ANNUALISED JOB PLANNING

10.1 There may be some consultants/SAS Doctors who have activities that do not fall on a regular weekly basis and therefore do not lend themselves to preparing a weekly job plan. Therefore it will be necessary to have an element of their job plan annualised. However, the principles of job planning remain unchanged.

10.2 Where a consultant/SAS Doctor undertakes irregular clinics or additional roles, this will need to be annualized. For example, if a consultant has been approved to take on an examining role (EPA's) which will involve approximately 5 days per year – this is annualized as follows: 5 full days per year equate to 40 hours/yr, or 10 programmed activities. 10 PA's divided by 42 weeks = 0.23 PA per week.

10.3 As with all aspects of Job planning the decision whether to annualise a Job plan or not must be by mutual agreement. At the outset, managers and doctors should agree that activity relates to measurable outputs and that arrangements reflect the professional nature of the contract and doctors continuing responsibility for care as set out in the GMC Good Medical Practice.

10.4 The electronic job planning system is able to capture and calculate accurately many of the complexities of annualisation. Help and assistance is also available from the Medical HR Department where necessary. Examples of annualisation of the contract can also be found in the BMA/NHS Employers "*A guide to Consultant Job Planning – Find the Link in Section 1 of this document*". Annualised activities recorded under "no specified day" should only reflect those activities which occur irregularly during the year.

## 11. ON-CALL ACTIVITY

11.1 This is recognised in two ways: an availability supplement and a PA allowance for time worked. All consultants on the same rota at the same frequency should have the same availability supplement and the same PA allowance for hours worked. Associate Medical Directors and Clinical Directors should monitor this on a regular basis given the frequency of new appointments and changes in participation levels.

11.2 On-call rotas should be monitored by a diary exercise at least every two years, more often if a change has taken place or if either side requires a review. It is a mandatory requirement for consultants to undertake a diary card exercise when asked to do so. The definition of on-call duties and emergency work is in schedules 8 and 16 of the Terms and Conditions. Depending on the frequency of on-call duties, it is recommended that the diary exercise should include at least two to three on-call cycles for the outgoing job plan year to determine a fair average.

11.3 Allocations for unpredictable emergency work must be evidenced by a diary data on a team basis. For example:

- A diary analysis indicates 37 hours of unpredictable on-call activity worked by the team in 1 week.
- 37 hours / 3 = 12.3 PA's of unpredictable on-call activity per week for the team.
- To allow for prospective cover – 12.3 x 52 weeks / 42 working weeks = 14.5 PA's.
- This must be divided by the number of consultants on the on-call rota e.g. 16 consultants on rota = 0.91 PA each for on-call.
- Therefore if a consultant team was offered 0.91 PA for unpredictable on-call, this equates to approximately 37 hours per week. It is useful to ask if this represents the actual workload. If not, a re-diary card exercise may need to be undertaken.



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11.4 Change to workload/New Appointment/Consultant leaving - All new consultants must have a Job Plan review within the first three months following their start date. This means that Clinical Directors will need to meet with new doctors in post within the first month to commence the job planning process.

11.5 *It is essential that if there has been a change to the workload or following a new appointment, the* on-call activity and PA allocation and on-call frequency for the team must be reviewed and the change notified to HR appropriately. For instance, if there has been a change to the on-call frequency e.g. High frequency (1 in 1 to 1 in 4); Medium frequency (1 in 5 to 1 in 8); Low frequency (1in9 or less frequent) which takes it from one category to another, a notification of this change must be completed immediately and the update reflected on the E Job planning system. **To avoid any over or under payments the Clinical Director must ensure the necessary changes are notified to the Medical HR Team for immediate action with payroll and this should subsequently be followed up with the necessary changes in Job Plans**.

**Consultants**

| **Frequency of on-call Rota** | **Value of on-call supplement as % of full time basic salary** | |
|---|---|---|
| | Category A | Category B |
| High Frequency 1:1 – 1:4 | 8% | 3% |
| Medium Frequency 1:5 – 1:8 | 5% | 2% |
| Low Frequency 1:9 less frequent | 3% | 1% |

**Associate Specialists and SAS Doctors**

| **Frequency of on-call Rota** | |
|---|---|
| | % of Basic Salary |
| High Frequency 1:1 – 1:4 | 6% |
| Medium Frequency 1:5 – 1:8 | 4% |
| 1:8 less frequent | 2% |

## 12. TRAVEL TIME

12.1 Travelling time between a consultant's/SAS Doctors main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.

12.2 Where consultants/SAS Doctors are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).

12.3 Job Plans should be designed to minimize disruption of fixed clinical episodes by time spent traveling between sites e.g. arranging for a full day in one clinical area rather than movement between site A&B during the day.

12.4 Travel to and from work for HSC emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the doctors main place of work, after deducting the time normally spent travelling between home and main place of work.



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12.5 Working Example - If a consultant/SAS Doctor normally takes 45 minutes to travel from their base hospital (e.g. CAH) to an outlying clinic (e.g. DHH) and a doctor doesn't travel to base but goes straight from home to the outlying clinic, then they can claim for "excess time" in their job plan if it takes them longer to travel from home. Therefore if doctor X lives in Belfast and it takes them 1 hour to travel to DHH, then they could claim 15 minutes in their job plan. However if they lived further away and it took them 1.5 hours to travel to DHH straight from home (or they had to come to base first for clinical reasons) then they would claim 45 minutes in their job plan.

## 13. SUPPORTING PROFESSIONAL ACTIVITIES

13.1 In order for the Southern Trust to attract and retain medical staff, we want to ensure we foster and support a culture of continuing professional development, education and training. However, this does not mean that all doctors need necessarily be involved in all of these activities. The flexibility inherent in the contract would provide for the number of SPA PA's required to deliver agreed activities in a given department to be determined and allotted to those undertaking the work.

13.2 A minimum of 1.5 PA's for supporting professional activities should be allocated to all consultants and considered as the minimum time for a consultant's CPD for revalidation purposes. This allocation will be the same for full and part time consultants. A minimum of 1 PA for supporting professional activities should be allocated to all SAS doctors and considered as the minimum time for CPD revalidation purposes. (The difference from consultants reflects the differing contractual agreements)

13.3 Typical SPAs for CPD and revalidation includes; preparation for revalidation, personal study (e.g. CPD and attending trust educational meetings, grand rounds, audit meetings etc.); personal/professional administration e.g. preparation for appraisal and job planning, completing 360-degree feedback for colleagues etc.; mandatory training relevant to the specialty group, attendance at departmental audit and clinical governance meetings, contributing to national audits etc.; basic undergraduate and postgraduate teaching and attending regular specialty consultant meeting.

SPA work should be carried out on-site and timetabled, although it can be carried out off site with prior agreement of the Associate Medical Director. SPA should be protected time as far as practically possible with the appropriate facilities available to allow doctors to make best use of their CPD time. Any issues with the availability of appropriate facilities should be raised with the Clinical Director/Associate Medical Director. There may be flexibility on the timing and location of SPA activity but only after agreement with the CD/AMD and if this is included in an agreed job plan in advance. If a flexible SPA is agreed, it must be reviewed annually

## 14. ADDITIONAL HSC RESPONSIBILITIES & EXTERNAL DUTIES

14.1 **Additional HSC Responsibilities** – These are activities agreed between a consultant and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA's. This would include roles such as APLS/ALS Trainer, Appraiser, Clinical lead for an element of service, clinical tutor, formal undergraduate teaching role, NIMDTA formal educational supervisor, BMA, Medical Staff Committee etc. should be timetabled into job plans accompanied by clear specific objectives for this work.

14.2 Where a clinical director or other clinical lead post becomes available, the Associate Medical Director in consultation with the Medical Director/Service Director should undertake an internal



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expression of interest/appointment process. This will set out the nature of the role including time/PA allocation and the terms and conditions associated.

14.3 Each clinical manager needs to be aware of the roles of the consultant and how the roles are funded to ensure appropriate job planning. In some cases the allocation will vary among specialties, depending upon the required commitment and in some circumstances (e.g. Clinical Tutors), the number of junior doctors. Further guidance and support should be sought regarding teaching roles, their time commitments and job planning for them.

14.4 When an individual doctor is wishing to undertake a role within the wider HSC and/or seeking agreement from their Clinical Manager for the release of time within their job plan; they must complete the **SHSCT Additional HSC/External Duties Application Form** prior to acceptance. Service Directors must also been involved and advised of the commitment and its impact on delivering the job plan. The timing and duration of the role and an indication on whether the role is funded externally MUST accompany this request.

14.5 **External Duties** - The Trust would seek to facilitate consultants wherever possible for such work that is not directly for the Trust but is relevant to and in the interests of the wider HSC. All these roles require Trust approval and the **SHSCT Additional HSC /External Duties Application Form** must be completed prior to acceptance.

14.6 Where possible all Additional HSC or external duties MUST be included within the job plan with a clear time allocation and set within an agreed timeframe with a specific end date. It may be necessary to annualize due to the nature/irregular timing of the work. Clinical managers should seek to spread this work equitably across teams and the Trust where possible. Any agreement should acknowledge the importance of the priority of doctor's commitments to direct clinical care and supporting professional activities. Measurable objectives for this work MUST be discussed, agreed and be clearly specified on the job plan template.

14.7 Facilitating doctors for Additional HSC & external duties must be governed by the need to retain a balance between different elements of the job plan in a way that maintains the required delivery of services to patients in terms of both activity and quality. It is reasonable for the clinical manager to seek to secure/maintain required direct clinical care commitments.

14.8 Clinical Managers must keep copies of the External Duties/Additional HPSS Approval request form and provide details of such commitments to the Medical Director and the Senior Management Team in the Trust on request.

## 15. PRIVATE PRACTICE

15.1 Regular work for other providers must be identified on the job plan indicating time and location. Such work should not occur in remunerated PA time contracted to the Trust. It is the responsibility of the Clinical Director and the Consultant/SAS Doctor to ensure there is no double counting of time.

15.2 All consultants/SAS Doctors are expected to conform to the Northern Ireland Code of Conduct for Private Practice and the handbook concerning the management of private practice in Health Service Hospitals in Northern Ireland.



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## Appendix 1 – Additional HSC/External Duties Application Form

Southern Health and Social Care Trust

# Request to undertake Additional HSC Duties or External Duties

To be completed by the Consultant requesting approval

| **Personal details** | |
|---|---|
| Name: | |
| Specialty/Directorate: | |
| Base: | |

| **Proposed Duty** | |
|---|---|
| Request for: (please circle) **EXTERNAL DUTY** **ADDITIONAL HSC DUTY** | |
| Is this post externally funded?<br>If so, please provide full details: | |
| Details of appointment (e.g. local, regional, national, name of body / organisation): | |
| Please provide a full description of the proposed duty, including anticipated start date, number of days, location, frequency of the commitment, tenure of contract (end date) and any anticipated expenses (expenses should normally be met by the external body): | |
| Please give details of any other duties for which you have received approval this year, prior to this current request: | |

| **Impact on Regular Duties** |
|---|
| Please give details of current Job Plan (DCC & SPA PA allocation): |
| Can the proposed commitment be accommodated within your existing Job Plan without increasing PA's? (I.e. aggregation of workload across the year) ☐ **Yes** ☐ **No** |



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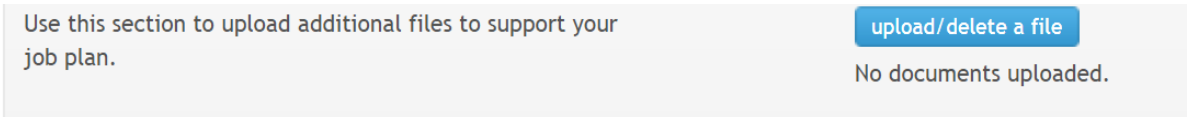
| |
|---|
| If No, please provide further details e.g. anticipated increase in PA's will a Job Plan Review be undertaken and/or reassessment of Job Plans across the specialty? What will be the impact on clinical commitments? |
| Will any fixed commitments in your existing job plan be cancelled to undertake this duty? ☐ **Yes** ☐ **No** |
| Will professional / study leave be used to undertake this activity? ☐ **Yes** ☐ **No** |
| **I understand I must seek approval from the Trust before accepting any external role that impacts upon my job plan. I am aware that any agreement is reviewed annually by the Trust.** |

| | |
|---|---|
| **Signed by Consultant:** | **Date:** |

| ***Approval Signatures*** | | |
|---|---|---|
| ***Some questions for the Clinical Manager to consider prior to approval**:*<br>*Has agreement has been sought from consultant colleagues in the specialty? Are they supportive of this commitment? How will it impact their job plans? Will it be possible to maintain direct clinical care commitments? Is this consultant group "overrepresented" for external duties? Does the Trust receive funding for this role? Is the role in the interests of the wider HSC?* | | |
| ***Associate Medical Director:*** | ***Date:*** | ***Review Date:*** |
| ***Director of Programme of Care:*** | ***Date:*** | ***Review Date:*** |

**This completed form should be completed and attached to the consultant's Job Plan template. The option to upload an associated document is available when editing your job plan under the Required Information section – see below:**




**A copy of the approved form should be emailed / posted to the Medical Director via their AD -** [redacted] **and the Medical Staffing Department.**

| ***Approval authorisation*** | |
|---|---|
| ***Medical Director:*** | **Date Agreed:** |



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# SHSCT Guidance on allocation of PA's for Additional HSC/External Responsibilities

PA allocation for all of these activities must have agreement of the Trust and reflect an accurate assessment of the time commitment required, considering the responsibilities & demands of the role, the size of the project/task and whether it is a single site, cross site, Trust level of regional level and/or in the case of teaching/training the number of doctors involved. The suggested PA allocations should only be used as a guide and actual allocations should reflect a thorough assessment of the specific role.

## ROLES NORMALLY CAPTURED UNDER ADDITIONAL HSC RESPONSIBILITIES / EXTERNAL DUTIES:

| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| NIMDTA Appointed Educational Supervisor | **Named NIMDTA Educational Supervisor** ***(This includes Foundation Education Supervisor roles)***<br><br>All trainees must have a named educational supervisor. In some circumstances this will be the same person as the clinical supervisor.<br>A **named educational supervisor** is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement or series of placements. The educational supervisor is the key person is bringing together all the relevant evidence for a placement which enables a decision to be made as to whether it is safe for patients that a trainee should progress to the next stage of their training.<br><br>**Responsibilities of the Educational Supervisor**<br>1. Support the trainee in developing their learning portfolio and evidence of competency<br>2. Ensure trainee understanding of and engagement with the assessment process<br>3. Ensure trainee completion of workplace-based assessments<br>4. Review trainee progress against the curriculum and decide whether placements have been completed successfully<br>5. Agree the best use of Study Leave to achieve required competencies and experience<br>6. Ensure that the trainee receives appropriate career guidance and planning<br>7. Meet the trainee in private at agreed, protected times in a placement in accordance with curricula requirements to ensure he or she makes the expected clinical and educational progress<br>b. To conduct an induction interview within the first two weeks of a placement and develop a mutually agreed Learning Agreement and educational objectives and establish a supportive relationship<br>c. At mid-point to carry out an appraisal based on the Learning Agreement<br>d. At the end to carry out an appraisal to inform the trainee's ARCP<br>e. Give regular, honest and constructive feedback according to the stage and level of training, experience and competence of the trainee | **0.125 PA per trainee per week** | **NIMDTA Trainer Agreement**<br><br>**Additional HSC Responsibilities Approval proforma**<br><br>Allocations must be added to Job Plans to facilitate payment |



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

| | | | |
|---|---|---|---|
| | f. Be approachable and available to a trainee to give advice and guidance on clinical, administrative, organisational and governance issues and to provide opportunity for the trainee to raise issued relating to training and support and manage in accordance with HSC Trust and NIMDTA policies<br>g. Keep appropriate records of assessments<br>h. Document all meetings and associated outcomes/actions agreed in the portfolio and review development of the portfolio by the trainee<br>i. Liaise with others to share information over trainee progression<br>2. Attend meetings relevant to the educational supervision role and disseminate information to a trainee's Clinical Supervisor and the trainee as appropriate<br>3. Arrange for an appropriate colleague to fulfil the educational supervision role during any period of absence and inform the TPD if a period of absence will extend beyond 4 weeks.<br>4. Undertake a formal handover with the new Educational Supervisor. | | |

| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| NIMDTA Appointed Clinical Supervisor | **Named Clinical Supervisor**<br>For every placement, the doctor in training must have a named clinical supervisor. In some instances, this will be the same person as the educational supervisor.<br><br>A **named clinical supervisor** is a trainer who is responsible for overseeing a specified trainee's clinical work throughout their placement in a clinical environment and who is appropriately trained to do so. Their role is to lead on providing day-to-day supervision of trainees, reviewing a trainee's progress and providing constructive feedback.<br><br>**Responsibilities of the Clinical Supervisor**<br>1. Should be involved with teaching and training the trainee in the workplace<br>2. Should help with both professional and personal development<br>3. Must offer a level of supervision of clinical activity appropriate to the competence and experience of the individual trainee.<br>4. Support the trainee through direct supervision, close supervision and regular discussions, review of cases and feedback<br>5. Organise induction to the clinical department (covering duties of the post, particular responsibilities, departmental meetings, senior cover, cross-specialty induction when cross-cover is required, handover arrangements, bleep policies)<br>6. Agree specific and realistic specialty learning objectives appropriate to the level of the individual trainee | **0.125 PA per trainee per week** | **Additional HSC Responsibilities Approval proforma**<br><br>Allocations must be added to Job Plans to facilitate payment |



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| | | | |
|---|---|---|---|
| | 7. Meet the trainee within a week of starting the placement and establish a supportive relationship<br>8. Provide regular review during the placement both formally and informally to ensure that the trainee is obtaining the necessary experience, included supervised experience in practical procedures and give constructive feedback on performance<br>9. Perform and oversee the work-based assessments detailed in the portfolio<br>10. Encourage trainee attendance at formal education sessions<br>11. Ensure a suitable timetable to allow completion of the requirements of the specific curriculum<br>12. Ensure that relevant information about progress and performance is made available to the educational supervisor to inform the end of placement appraisal and the Educational Supervisor's report<br>13. Should inform the Educational Supervisor should the performance of any individual trainee give rise to concern | | |

| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| Trust Service Development Lead | Many directorate business and related meetings [service/clinical development] are scheduled during existing SPA or DCC, and do not therefore attract further SPA allocation..<br><br>A Director and AMD however can agree to "commission" and recommend specific, approved time limited service development projects providing full details of activities/ times and expected outcomes had been provided. In order to attract extra recognition these activities must be over and above time given in the job plan and not displace existing SPA or DCC time. These duties will only arise as a result of a request from an Operational Directorate team. | **Dependent on specific project and time intensity** | Formal Expression of Interest process<br><br>Allocations must be added to Job Plans to facilitate payment |

| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| NIMDTA appointed ***Foundation*** Programme Director | Responsible for the overall management and quality control of a foundation programme that consists of 20-40 placements designed for foundation training across the region. | **1 PA per week** | Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan. |



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| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| NIMDTA appointed Training Programme Director | Responsible for the management of both trainees and their specialty training programme. | **Determined by NIMDTA** | Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan. |
| NIMDTA appointed Head of school / Deputy Head of school | Each School is headed by a Director of Postgraduate Training, known as Head of School. This individual would be a joint Deanery/College appointment, accountable to the Postgraduate Dean, and professionally to a designated College Officer. Specific deputy directors could be appointed Deputy Head of School as justified by workload and available resources, some of whom might take on specific roles such as Flexible Training. | **Determined by NIMDTA** | Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan. |
| Royal College Roles e.g.<br>College Tutor<br>Regional Advisor | These roles fall under External Duties and are not ordinarily funded and as such should have prior Trust approval and specify the duration of the role.<br><br>Responsibilities may include organizing and monitoring the delivery of training on behalf of the college and providing an educational leadership role. | **At the discretion of the Trust as these are often unfunded – between 0.25PA to 1PA may be allocated depending on the size of the specialty and number of trainees and if funding available to support.** | External Duties Approval Proforma<br><br>Approval letter from College is desirable<br><br>Consultant responsible the approved allocation is added to their own job plan. |



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| Role | Role Description | Suggested Allocation | Approval |
|---|---|---|---|
| Trust Appointed Associate Medical Directors | The Role of the Associate Medical Director is set out in a separate document which outlines the core responsibilities including operational effectiveness of services, governance and professional practice standards and medical management. | Responsibility Allowance of £15,200 pa<br><br>Specific time between 1PA - 3PA's to be allocated in Job Plans – to be agreed by Director/Med Director. | Formal Recruitment Process<br>Allocations must be added to Job Plans to facilitate payment |
| Trust Appointed Non Operational Associate Medical Directors | Associate Medical Director for Education & Training<br>Associate Medical Director for Research & Development | Specific time to be allocated in Job Plans – to be agreed by Director/Med Director. | Formal Recruitment Process<br>Allocations must be added to Job Plans to facilitate payment |
| Trust Appointed Co-Director – Undergraduate Medical Education | Co-Director - Undergraduate Medical Education CAH<br>Co-Director Medical Education & Training – Daisy Hill Hospital<br><br>Clinical Sub Dean (QUB) for undergraduate Medical Education | Salaried Part Time Position.<br>Specific time to be allocated in Job Plans – to be agreed by Director/Med Director. | Formal Recruitment Process<br>Allocations must be added to Job Plans to facilitate payment |
| Trust Appointed Clinical Directors | Clinical Directors | Responsibility Allowance of £7,600 pa<br><br>Specific time to be allocated in Job Plans – to be agreed by Director/AMD. | Formal Recruitment Process<br>Allocations must be added to Job Plans to facilitate payment |



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## ROLES NORMALLY CAPTURED UNDER ADDITIONAL SPA ALLOCATION:

| Role | Role Description | Suggested PA Allocation | Approval From |
|---|---|---|---|
| SUMDE Undergraduate Teaching | It is agreed that recognition will be given for formal undergraduate teaching roles & commitments subject to details of full year timetable. As indicated above teaching delivered within DCC time can be mentioned in a job plan, but an SPA allocation will only be made if the teaching is delivered over and above, and in separate time. The PA allocation will be assessed on an annualised basis. The Trust is paid for this work through SUMDE monies, and will ultimately track the money to match income with expenditure. Verification of roles and responsibilities will be sought from AMD Medical Education. | Sub Dean for Under-graduate Education will determine appropriate PA allocation based on the amount of dedicated teaching time delivered including a time allowance for admin and assessment time. An annualized PA allocation is determined and this should then be factored into job plans. | Consultant responsible the approved allocation is added to their own job plan. |
| Southern Trust Appraiser | It is agreed that recognition would be given for the role of appraiser on the basis of the Trust Appraisal Scheme [4 hours per appraisee per year), including reading the folder prior to the meeting, the meeting itself, and the subsequent writing up of the record of the meeting, and attending to the duties of an appraiser as outlined in the Trust's scheme]] It is agreed that a consultant/SAS Doctor preparing for and attending his/her own appraisal will do so within core SPA time. | **1 PA per appraisee per year** | Consultant responsible the approved allocation is added to their own job plan. |
| Southern Trust Complex Rota organizer | It is agreed that ongoing responsibility for rolling rotas (consultant or junior) should not attract additional SPA allocation. A responsibility for rotas not undertaken by the generality of consultants can be recognized where this is particularly onerous. This includes a very complex rota for example where it involves liaison with other clinical disciplines and/or efficient use of or allocation of clinical staff time [e.g. a theatre rota to match nursing' surgical and anaesthetic resources]. | This will be specialty specific – as ordinarily most rota's wouldn't be classed as complex and as such should be managed within existing PA allocations. | Where approved - consultant responsible the approved allocation is added to their own job plan. |
| Chair of M&M Meetings | | | |



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## 1. BACKGROUND & PRINCIPLES

- In 2004 the new consultant contract introduced a new and more robust system of job planning, which was also included in the new Speicalty Doctor and Associate Specialist contracts. The purpose of this local guide is to set out the Trust's approach to Job planning. The guidance also takes account of the introduction of an Allocate electronic Job Planning system.

- This document does not amend, discard or move away from national contracts, terms and conditions. It provides a framework for Job Planning to ensure consistency across the Trust. Please also refer to:

    - Department of Health Terms and Conditions of Service: Link Here
    - Consultant Job Planning – A Best Practice Guide July 2017 NHS Improvement July 2017 Guide
    - Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland April 2008: DOH Regional Guide April 2008 and the other associated documents
    - Regional Guidance on Job Planning for Medical & Dental SAS & AS Doctors in Northern Ireland: DOH Regional Guidance on Job Planning for SAS and Associate Specialist Doctors
    - Zircadian/Allocate Guide to E Job planning - Guide for Doctors & E Job planning Guide for Managers
    - SHSCT Medical Staff Annual Leave Guidance

- Job planning is a contractual requirement for consultants/SAS Doctors and employers.

- Directorate management teams and the consultants/SAS Doctors should approach the Job Planning process with professionalism, honesty, openness and accountability on all parts.

- The job planning process is prospective; therefore decisions made, will affect future work and payments. A prospective commencement date must be stated on the e-job plan.

- Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty.

- All Job Plans over 12 PA's will be reviewed by the Senior Management Team periodically to ensure they are not out-with EWTD legislation. All doctors must ensure they comply with their responsibilities under this legislation to safeguard safe weekly working hours. This includes all hours worked in private practice and/or the independent sector.

## 2. JOB PLANNING CONSISTENCY COMMITTEE

2.1 To promote and facilitate Best Practice, A Job Planning Consistency Committee will be established to ensure job planning is consistent between specialties and across the Trust. The role of this group will be to provide assurance that job planning is in line with regional and Trust guidelines. It is anticipated this will be led by the Medical Director (or deputy) and involve input from the medical and service managers. A summary report will also be issued to BMA LNC annually. This group will review practices and suggest changes to help improve the job planning process on a prospective basis for the following year, with any changes being agreed through LNC.



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

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Job Planning Steering Group

## Terms of Reference

**Aim**

The aim of the Job Planning Steering Group is to ensure that:

- Processes are in place so that all directly employed and medium to long term locum medical staff working for the Trust have a job plan in place.
- Processes are in place so that all directly employed and medium to long term locum medical staff have job plans agreed and signed off prospectively on an annual basis
- There is consistency of approach in job planning between specialties, divisions and directorates and that this is reflected in the resultant job plans.
- Developments in job planning and consider issues of concern relating to job planning are discussed taking account of Trust priorities and objectives.
- All job plans include, as far as is reasonably practical, quantifiable levels of activity and outcomes, either at team and/or individual level.
- The Trust's Job Planning Policy is kept up to date.

**Guiding Principles and Values**

The overarching principles of this Job Planning Steering Group are:

- To ensure effective decision making around solutions to meet identified priorities, which offer the best value for money from investment of public funding.

- To consider progress on achieving completed job plans which align to the Trust's strategic priorities

The approach to achieving these aims will be underpinned by a set of values that demonstrate that job planning is:-

- undertaken in a spirit of collaboration and cooperation
- mutually agreed and not imposed
- completed in good time with at least annual review
- reflective of the professionalism of being a doctor
- agreed taking account of the career development and aspirations of the doctor
- focused on maintaining high-quality care
- transparent, fair and honest
- agreed taking into account the individual doctor's area(s) of expertise
- agreed with adequate provision for any activities mandated by regulating agencies
- responsive to appraisal discussion

DRAFT

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

**Membership**

| | |
|---|---|
| Dr Stephen Austin | Medical Director |
| Vivienne Toal | Human Resources and Organisational Development Director |
| Fiona Stevenson | Assistant Director Human Resources & Organisational Development |
| Zoe Parks | Senior Manager – Medical HR |
| Dr Aisling Diamond | Deputy Medical Director – Medical Education and Workforce |
| Simon Gibson | Assistant Director – Medical Education and Workforce |
| All DMDs | |
| All Operational Directors | |

**Frequency of meetings**

The Steering Group will meet four times per year – with urgent decisions / approval, where necessary and possible, made electronically in between meetings.

**Roles and Responsibilities**

1. To ensure that the act of job planning is a systematic activity which produces clarity of expectation for the Trust and doctor about the use of time and resources to meet individual service objectives.

2. To clearly define a process, timetable and targets for ensuring the prospective delivery of fair, equitable job plans across the consultant and SAS medical workforce working to the agreed set of guiding principles and values

3. To ensure a transparent and fair approach is undertaken for all consultant and SAS medical staff engaged in activities outside their core duties, such as undertaking educational supervision or chairing M&M

4. To allow the job planning process supports succession planning within specialties, to ensure timely recruitment of key staff

5. To ensure a consistent approach is taken across the Trust across all Divisions.

DRAFT

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

Board development days and so on, where we would have had more of a discussion. I think it would have been better if we had had three executive professional directors, social work, medicine, nursing, as opposed to just me because everyone else is focused on activity.

162 Q. It is a big remit for one person.

A. I think the balance of power, shall we say, might have been tipped differently. I think the Trust, if I'm right, because I didn't know but I was looking through the evidence, after I left, at some point or other they did create an Executive Director of Nursing, which I think is a big step forward. 15:33

163 Q. On a slightly different tack, there's quite a lot about job planning in our various bits of evidence; it's a big issue for most Trusts. My experience of job planning is that there is an opportunity to put objectives into job plans and team job plans in terms of standards to be achieved, but I can't see that featuring in the job plans we've seen here. Why is that? Why was there no inclusion, or was it simply thought that it would be added later? Do you have any perspective? 15:33

A. Yes, I think it was that that would be a name. Just getting the basics done in terms of the baseline job planning was a massive effort and very, very slow. Using job planning in a more proactive sense like that, perhaps it did come to that after I left but we hadn't got that far in 2014/'15. 15:34

or tardiness in respect of compliance with those.

A. Yes. So when I think about that history, and I suppose - and I appreciate they've only been recently published, but when you look at the recommendations that have come out of the Neurology Inquiry in relation to appraisal, those mirror some of what we were dealing with in relation to Mr. O'Brien. And in relation to job planning obviously, you know, very tardy to sign off in relation to that too. I had, you know, he had been part of a Maintaining High Professional Standards Investigation. As I became increasingly familiar with the case, you know, I became aware of other aspects to his practice that there had been worry about previously but had been closed off, and I had referred him to the GMC. So this was someone that I was concerned about. 10:34 10:34 10:35

25 Q. Mm-hmm. And I suppose the focus of my question is, you, and those employed at senior level within the system, knew about these shortcomings, the non-compliance, the team work issue, the delays in co-operating with job planning appraisal. That's your evidence, or your perspective on it, and I'm sure Mr. O'Brien may have a different perspective. But from your perspective, with the knowledge of those things, what was the reaction to it? What was the response to this knowledge? And do you think it was satisfactory, looking at it from today's standpoint? 10:35 10:36

A. So, the overall response to this has been, as I mentioned earlier, a revision in our systems and processes in relation to how we manage appraisal,

re-validation and job planning. We now have much tighter structures around all of that. There's very timely escalation in relation to any of the challenges within all of that, and it's dealt with, you know, personally and in groups to try and help people get over the line. So, when I look at the history of the appraisal and job planning before, the numbers were low. I mean as of today we're sitting at over 90% compliance with appraisal. And job planning we're sitting at over 60% of compliance with that as we come into the new financial year. That's much better than it was previously. I think again with the training that has been done, you know, in connection between the Medical Director's office and the Director of Human Resource's office in relation to bringing all levels of staff to a greater understanding of their roles and responsibilities in relation to speaking up, whistleblowing, reporting low level concerns, you know, how that's escalated. You know, we've done training in relation to all of that to improve the visibility of all of that, and the systems and processes that are in place now are taken very seriously. I now get monthly reports in relation to how all of that is progressing, it's discussed at Senior Leadership Team, Trust Board, it's through the whole organisation in terms of being mindful that these systems and processes are there for a purpose and that we need to take them seriously and respond to them if we have concerns.

10:36 10:37 10:37 10:37 10:38

26 Q. But you're not saying - and we'll come later in your

## Clegg, Malcolm

**From:** aidanpobrien [Personal Information redacted by the USI]
**Sent:** 10 November 2011 00:56
**To:** Clegg, Malcolm
**Subject:** Re: Amended 2011/12 Job Plan

Malcolm,

Thank you for your email of 03/11/11, and for clarifying that the total PAs accompanying the Amended Job Plan will be 12.75.

As discussed with you yesterday, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I has brought attention, in writing and verbally, and over a period of two months, to the physical impossibility of earlier Job Plans offered, a possible (whether acceptable) Job Plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and accepted, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate.

Aidan O'Brien

-----Original Message-----
From: Clegg, Malcolm [Personal Information redacted by USI]
To: aidanpobrien [Personal Information redacted by USI]
Sent: Thu, 3 Nov 2011 12:16
Subject: RE: Amended 2011/12 Job Plan

Mr O'Brien,

The hours in the amended job plan total 12.63 PAs, so when this is rounded to the nearest 0.25 PA it results in a total of 12.75 PAs.

With reference to the effective date of the job plan, it had originally been intended that your job plan would be effective from 1st September 2011; however because of delays with Facilitation etc this will no longer be appropriate. If you are prepared to accept the amended job plan it is expected that this will become effective from 1st October 2011. This is the same date that has been applied to one of your consultant colleagues who has also accepted a reduced job plan in Urology.

I trust this helps to clarify your queries.

Regards



Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Subject: FW: Amended 2011/12 Job Plan
From: Clegg, Malcolm [redacted]
To: Mackle, Eamon <[redacted], Corrigan, Martina
<[redacted]>
Sent: 11/16/2011, 1:03:57 PM
Mr Mackle/ Martina,

Please see response from Mr O'Brien to his job plan offer following Facilitation.

I have responded to Mr O'Brien today to inform him that arrangements have been made with salaries and wages to implement the 12.75 PA job plan from 1st October 2011. I also advised him that I would be notifying you both of the comments he had made as you might need to discuss these issues further with him.

We have decided to proceed with implementation of the 12.75 PA job plan from 1st October 2011 as Mr O'Brien never formally requested an appeal despite now indicating his disagreement with the job plan. I do feel however that we cannot ignore Mr O'Brien's comments. Mr O'Brien was informed in his notification letter following Facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made by Mr O'Brien that we follow through with this.

Regards

Malcolm

Malcolm Clegg
Medical Staffing Department
Southern Health and Social Care Trust
Craigavon Area Hospital
BT63 5QQ

Tel: [redacted]

From: aidanpobrien [redacted]
Sent: 10 November 2011 00:56
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Malcolm,

Thank you for your email of 03/11/11, and for clarifying that the total PAs accompanying the Amended Job Plan will be 12.75.

As discussed with you yesterday, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I has brought attention, in writing and verbally, and over a period of two months, to the physical impossibility of earlier Job Plans offered, a possible (whether acceptable) Job Plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and accepted, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to



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completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate.

Aidan O'Brien



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It is important to make clear that I am required to comply with Trust Policies and Procedures. Disciplinary procedures should only be used or invoked where it is considered that I am in breach of Trust policies or where my professional competence has been called into question.

The most relevant Trust Policy is entitled *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance,* dated 23 September 2010 (hereafter referred to as the "Trust Guidelines". These guidelines were updated in October 2017. However, it is the 2010 guidelines that are relevant to the events of 2016 and the formal investigation. I will make extensive reference to the Trust Guidelines throughout this grievance. It is attached in the Schedule of Documents at Tab 4. It is this document and the processes established within it that form part of my contract of employment.

The document entitled *Maintaining High Professional Standards in Modern HPSS* issued by the English Department of Health, Social Services and Public Policy in November 2005 is **not** part of my contract. This is made clear by Clause 32 of my contract outlined above.

### 2.3 Events before 30th December 2016

I have provided an extensive historical context for the concerns about my administrative backlog to the Case Investigator, Dr Chada. This response is attached in the Schedule at Tab 5. I do not intend to repeat the full context in this correspondence. In summary, I have provided detail of the pressures that I was under for many years with waiting lists for both in-patient treatment and review, and how I was using available time to ease that backlog. There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. **This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming**. It is clear from the witness statements provided in the investigation that my administrative backlog was known to Trust managers for a very considerable period of time prior to 2016.

The problems became more acute owing to additional pressures that built up between 2012 and 2016. I was provided with 2 hours and 40 minutes of patient related, administration time per week in 2015 (Tab 6) and 2 hours per week in 2016 (Tab 7) in my job plan. I described in my response, the additional commitments required following appointment as Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of Urology MDM in April 2012, and as Lead Clinician of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology in January 2013. These appointments were followed by a two year period of time when both the Southern Trust's and Northern Ireland's regional urological oncology services were preparing for National Peer Review in June 2015.

I was not provided with or allocated any time for any of these undertakings during the years 2012 to 2014. The most onerous and time consuming was previewing all cases to be discussed at MDM which I chaired every Thursday afternoon. This required three to four hours of work, which I typically had to undertake from 10 pm each Wednesday evening, having operated to 8 pm. To relieve the burden, I introduced a rotating chairmanship of MDM with two of my colleagues, beginning in November 2014. Thereafter, I was provided with an additional 3 hours to prepare for chairing MDM as were my two colleagues, from 2015 onwards.

However, no time was allocated in my job plan for the remaining commitments at all during the years 2012 to 2016. By the time that the Southern Trust MDT was subjected to National



Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Peer Review in June 2015, we did not have a single patient breaching a cancer timeline since the end of 2014. This had been achieved by my ensuring that all patients were reviewed and operated upon within the required timeline, either by their nominated consultant urologist, or by myself, if the nominated consultant was unavailable to do so. All of these commitments and undertakings required considerable administration, a fact of which Management was aware. I did raise with Mrs. Martina Corrigan, as Head of Service, on more than one occasion the prospect of having time allocated in my job plan to facilitate these commitments, but no time was allocated or other commitments reduced. Despite having done so, no remedial or supportive plan or action was put in place to alleviate me of this overwhelming burden, which then gave rise to an administrative backlog in terms of dictation of letters, and which became a subject of concern.

Additionally, I found it impossible to complete triage of all referrals whilst Urologist of the Week, a system that commenced in 2014. Again, Trust managers were aware of this, as I had advised them myself. I undertook all Red Flag triage but not the triage of urgent and routine referrals and several of the witnesses have described in their statements my stating that I could not do it. Ms Martina Corrigan stated "Mr O'Brien complained that he didn't have time to do triage because of his patient care or admin commitments." Mr Michael Young stated "I know Mr O'Brien finds triage arduous and he would often say he had difficulty completing triage on a timely basis." Mr Tony Glackin stated "Mr O'Brien frequently expressed a view that he did not have time to do triage and he flagged that he couldn't manage the situation"

In fact, for a period of approximately 4-6 months in 2014, Mr Young completed triage of referrals for me. This was approved by Management because of the my additional undertakings and commitments. This was a clear recognition that these additional commitments made it impossible for me to complete my administration. However, the commitments remained throughout 2015 and 2016, long after Mr Young had stopped completing my triage.

As a consequence of Management's awareness of triage not being completed by me, at a meeting of consultant urologists with all personnel from the Office of Cancer Services, the Appointments Office and Medical Records involved in the appointment of patients following referral, we were advised that a default system had been put in place to ensure that patients were appointed in chronological order within the category of urgency by which their referral had been submitted.

I also do believe that it is critically important to appreciate the contextual distinction between the triage of Red Flag referrals on the one hand, and Urgent and Routine referrals on the other. Referrals are designated Red Flag by the referrer when a malignancy has been detected or suspected or a significant risk factor of malignancy is present. Upon triage, unless there is good reason, the Red Flag status will be retained, and the patient's assessment and management will be processed in a timely manner, and ideally within the prescribed cancer timelines. An urgent referral may be due to a detected or suspected condition which could be an even greater threat to the patient's life or future health, but which will not be processed with the same alacrity, or within any specified timeline, as does a Red Flag referral. During these recent years, the waiting times for a first consultation for urgent and routine referrals has increased relentlessly, currently 74 weeks for an urgent referral and 146 weeks for a routine referral. The only way of mitigating risk consequential upon such long waiting times, is by arranging further investigations, initiating treatment, informing referrer and patient alike, essentially undertaking a virtual consultation. Doing so necessitates time. The only way of spending such time is to compromise upon the time required to provide optimal care of inpatients while urologist of the week, or



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## Inpatient Operating 2013 - 2016

| | | |
|---|---|---|
| 2013: | Job Plan | 70 sessions |
| | Actual done | 113 |
| 2014: | Job Plan | 70 sessions |
| | Actual done | 101.25 |
| 2015: | Job Plan | 70 |
| | Actual done | 95.5 |
| 2016: | Job Plan | 61 |
| | Actual done | 83.25 |

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

Received from Tughans OBO Mr Aidan O'Brien on 06/12/21. Annotated by the Urology Services Inquiry.

That's everything sorted, I believe, Mr. Wolfe. Sorry for interrupting.

120 Q. MR. WOLFE KC: In the context of the points you make to Dr. Khan about the lack of management support, I just want to draw out a theme from your Section 21 statement. AOB-02029. This is your grievance that you put in towards the end of 2018. If we just scroll down to the fourth paragraph. You say you have provided to Dr. Chada details of the pressures that you were under for many years with waiting lists for both inpatient treatment and review, and "how I was using available time to ease that backlog". You say: 14:09 14:10

"There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming". 14:10

Just to draw that out a little, Mr. O'Brien. Is that, in more specific terms, you saying that, to use your description earlier this morning, you were spending a lot of the time at the back of the operation doing theatre work to help ease these backlogs and these pressures, and there is a correlation between doing that work, given that there's only so many hours in the day, and the falling behind aspect, which is described here and was to be the subject, at least in part, of 14:11 14:11

the MHPS investigation?

A. That's accurate and fair. It's a trade-off, really. It's making judgment calls. The beneficiary of any particular week or day can be different from the next week or day. 14:12

121 Q. I just want to show the Inquiry, as you say the Trust knew this and maybe this is one illustration of it. AOB-00686. Just scroll down to the page so we can see Mrs. Corrigan's... Thank you. 14:12

Martina is writing to you in relation to triage:

"Can you advise please when these will be triaged".

Up the page, Heather Trouton to Martina Corrigan: 14:13

"If you don't get a response by Wednesday can you please advise or escalate". Then Martina Corrigan to Heater Trouton: "Aidan and Monica are on annual leave this week but he normally does this sort of admin when 14:13 he is off so I will advise next week if this has not been sorted".

Was that part of your pattern, playing catch-up at convenient times because you spent a lot of time at the 14:13 back of the house doing the theatre work?

A. That's definitely the case. That was the case and had been for all of my working life at the Trust.

122 Q. In your engagement with Dr. Chada, you presented her

with Appendix 11, which was an outline of your various commitments beyond the administration requirements of your role. Let's just take a look at that. It's at AOB-10653. Appendix 11, then scroll down.

14:14

Here you are seeking to illustrate, I think by reference to your job plan, what you were doing by way of inpatient operating over and above the commitment expected from you in your job plan. Is that the proper way to put it?

14:15

A. That's the proper way to put it, yes.

123 Q. You say for 2016, which is obviously an important year in our chronology, that the job plan required 61. Is that 61 sessions; PAs?

A. 61 sessions, yes.

14:15

124 Q. And you performed 83.25. Do you multiply each session by four to get the hours?

A. You do.

125 Q. Is that the way to do it? Yes.

14:15

You record at the bottom:

"All of this additional operating was directed to those patients in most need".

14:16

Another document which is on this point which we find that you've disclosed, AOB-23225. Is this you drilling down and illustrating in greater detail the 2016 figure that we've just looked at?

A. That is correct.
126 Q. Are these your own records or are these hospital Trust records?
A. No, these are mine. I have constructed this record.
127 Q. Yes. The session figure, is that something that the Trust would have a record? 14:16
A. Oh, they would have. Absolutely.
128 Q. Just scrolling down through it. Over the next page, please, takes us all the way through the year, and obviously then you yourself go into - without dwelling on the detail - you yourself go off work for medical reasons in November 2016? 14:17
A. Yes.
129 Q. So it brings us up to then. Just working up from the bottom here, here we have your job plan, 58. A matter of fine detail perhaps, the last document we looked at had your job plan at 61 sessions. Maybe you can have a think about that. If you feel you can clarify that, please do. 14:17

14:17

The 83.25 sessions is the same figure as we saw in the previous document but then you add to that, I suppose, follow-up on each of these patients, whether it is perioperative care; is that after the theatre?
A. So, normally we would be allowed for one hour prior to the commencement of theatre, you know, with the patients, and half an hour afterwards. I found it necessary and reasonable to allocate an hour of administrative time per session as well, making up that 14:18

total.

130 Q. These are estimates made by you --

A. Yes, yes.

131 Q. -- of the commitment to get a patient pre-theatre, through theatre and out the other end? 14:18

A. Yes, yes. The 1.5 of perioperative patient care would be quite standard surrounding to bookend an operating day.

132 Q. This document, you'll have to forgive me, I'm not quite sure of the circumstances in which this particular 14:19 document was developed. I know that the one I first showed you was for Dr. Chada's investigation. This is a follow-up on that, is it?

A. It is. The previous one was almost the cover summary document, and I did this here for all of those years of 14:19 2013 up to '16. The same as this.

133 Q. Is it in broad terms? There may be other purposes for it but is this to attempt to demonstrate or illustrate how many hours in the working year were devoted to X?

A. Yes. 14:19

134 Q. And when you look at the number of hours over and above your job plan, I assume you are suggesting to the Inquiry through me that there weren't enough hours available to do all the administrative tasks that the Trust required of you? 14:20

A. That is exactly right. Yes.

135 Q. Okay. How does it come about, Mr. O'Brien, that in circumstances where you know that the basic requirements of your role - the triage, the

administration after clinics, those kind of things - you know that all of those ducks aren't in a row, those tasks are not being completed by you in the way that the Trust would want. So, those basic tasks aren't being performed. But are you putting your hand up and volunteering to do over and above tasks in theatre, obviously for the good reason of tending to people in pain and distress and difficulty, but with the full knowledge that you're doing that and the basic stuff isn't being done? 14:20 14:21

A. Well, it's a combination of both. For example, in 2013 - I've have made reference to it in my witness statement - where there was a ministerial target, I think, to meet 35 weeks maximum waiting time by 30th September. Having achieved that, then for 31st December, we had to meet a 26-week target. It is a combination of expectation on the part of the Trust to do additionality, to meet ministerial targets, and it is me volunteering for those reasons at other times as well. It's a mixture in there. 14:21 14:22

136 Q. Is there a financial incentive to doing these sessions?

A. No. If you were to scroll back upwards, most of the -- in the early years, I did all of that extended operating on typically a Wednesday, the extended bit, unpaid. If there's work done on a Saturday, it would typically be paid in this later year. For example, 27th August may have been paid, I can't recall. Friday, not at all. So, once again, there may have been an additional payment when finance was available 14:22

numbers of charts, that was very definitely not known, that I think would have been --

294 Q. Is that not a serious incident in its own, really? I mean, what would your attitude to that have been at the time? 13:26

A. The number of the charts, those number of charts, that is a serious incident, but I suppose by that stage it was beyond that, it was into raised it with Richard Wright for advice on how to manage it, et cetera. I suppose some things may not have made it directly to 13:26 have been an SAI when they are being actioned and followed up by the team, by the management team. If that's what you are asking me, sorry, I am not sure --

295 Q. I am trying to get sort of what was the culture in terms of understanding the risk to Patient Safety from 13:27 these issues which start off as maybe it's a small issue, and actually, when you think about it, it's quite a big issue?

A. I don't think that was understood. As I said, I think it was he was judged on the basis of what people 13:27 thought of him rather than just on the facts alone. When you see it tabulated it's very difficult to ignore it now. In fact, it's impossible to ignore now.

296 Q. It's obviously easier for us with hindsight but I'm just trying to get an idea of what the culture was 13:27 like. Another cultural issue that comes out is this issue of job planning where job planning is meant to be a tool for managing doctors to some extent, but with job planning best practice would be that you sit the

team down and you work out what work needs to be done and you come to an agreement. You can also set objectives for the team and so on. What was the general direction given to you as Associate Medical Director for what you needed to do with job planning, and how did that feel as Associate Medical Director and were you able to do what you needed to do? 13:28

A. There was great difficulty doing it. As you can see, there was over a prolonged time trying to get agreement. They would not agree. In fact, Mr. O'Brien was not prepared to agree to a job plan with any reduction in PAs, and ultimately his salary. 13:28

297 Q. Did you sit down with the team of urologists and do this in an open way?

A. A lot of the job planning earlier on was done through the Monday evenings trying to agree objectives and how it would be done and how we'd work them, et cetera. It wasn't -- it may have been set out but it wasn't -- you know, there was a lot of pushback. 13:28

298 Q. Yes. Okay. You didn't use job planning individually with objectives for each Consultant in that way? I can't see that in the paperwork. 13:29

A. No, job planning didn't entail that and still, to my knowledge, does not entail that for any of the --

299 Q. No. The private patient issue has come up, mainly from some of the witnesses so far, as a significant issue. Just in simple terms, the Trust has a private patient policy, I understand, which says that if you see someone privately and you bring them into hospital you 13:29

further kind of engagement.

278 Q. But you accept their right to do that in terms of --

A. Oh, absolutely. Yes.

279 Q. Did you ring anyone up? I mean who was your 'phone a friend' in terms of a senior medical colleague to say 'what do I do with this?' Because you said, didn't you? "What am I to do?" 15:02

A. I didn't ring anybody else.

280 Q. Why didn't you?

A. Because after all of those years I was in that same place, dealing with those same concerns, and the more -- the other concerns I have articulated. In an organisation -- and I'm not being critical of the organisation for the sake of criticism or to be critical of this organisation in which I worked for 28 years. You know, in a circumstance, let's call it that, that hadn't seen adequate progression in providing a service adequate enough to enable us to work. 15:02 15:03

281 Q. I'll come on to some job planning in bits in a moment. But you didn't ring anyone. You didn't think of it. You didn't think, 'I know a senior, wise person to ring'? 15:03

A. No, not at all.

282 Q. Now, if at that meeting you'd been signposted to a senior medical critical friend, would that have been helpful? 15:03

A. That would have been helpful, yes.

283 Q. Okay. So, I'm going to ask a little bit about job

planning. Now, this is a really difficult area for most trusts, for most doctors. On the one hand it's really just about payment for time in some ways. However, generally it goes with some reasonable expectation of what you do in that time and productivity and all of that. Your job plan was never signed off because you didn't agree with it. Nevertheless, there's a missed opportunity. Did you sit down with your urology colleagues and do a kind of a team job planning exercise ever? 15:04

A. Never.

284 Q. No. So, you didn't discuss with each other roughly what sort of balance you should have between different kinds of programmed activities or anything like that?

A. No. You know, in terms of, for example, what Mr. Hanbury was talking about, in terms of our outpatient templates, they were quite uniform, you know. At the new clinic -- new patient clinic where you do as much as possible, as it were, the one-stop, so it was nine new patients per consultant, and if you had a registrar with you, it was another six, and reviews were 12, and so forth. 15:04 15:05

285 Q. But you didn't sit down as a team and say --

A. We did --

286 Q. What I'm trying to get to, did you sit down and say: 'We've got this much work to get through; we've got this many urologists, this is the capacity for theatre, this is the gap, this is what we need to make a case for. Were those discussions facilitated in any way by 15:05

a Clinical Director. Did you have anything like that?

A. Yeah, particularly in earlier years when there was -- it was always a mismatch. I think in my witness statement I have detailed how the mismatch was through various exercises where they were called waiting list initiatives -- 15:05

287 Q. I understand that. What I'm trying to get to is was the culture in the Trust such that you would, every year, go through the requirements for the Department, the requirements on individual -- 15:06

A. No, no. It wasn't organised, no.

288 Q. -- and attached to the job planning some sort of team or individual objectives as to what you were trying to do. Did you do it or not?

A. No. 15:06

289 Q. Can you describe any mechanism by which, on an annual basis, for example, you were able to highlight the demand capacity mismatch and attach it to strategic plans for the service. Were you involved in that on a regular basis. 15:06

A. No, not on a regular basis.

DR. SWART: That's all from me. Thank you.

290 Q. CHAIR: Thank you. Just a couple of things from me. You talked there in answer, I think to Mr. Hanbury, about the issue of triage and disagreement among you and your colleagues about what that should be, and then there was, I think Mr. Glackin wrote to the Trust sort of saying - I think we've seen a letter somewhere, it wasn't drawn up in this - but saying what is expected 15:06

A. That's a blunt instrument, I think. In fact, our issue with job planning was that the number of PAs that Mr. O'Brien had for admin back in the time before it went to facilitation was in excess of any other clinicians. It wasn't a useful tool in that respect, you know.

MR. WOLFE KC: I've asked you about MHPS. Again, one would presume, given the working title to MHPS and the attendant guidelines, that any manager, whether on the operational or medical side, and perhaps more particularly on the medical side, would be very fully versed in that tool, not because it should be the item of first resort but it may well be the tool of eventual resort. Is it fair to say that your statement gives the impression of very little working knowledge or experience of that tool?

A. I would admit that I had little active knowledge of it. I would have relied, where I was concerned, of speaking to the Medical Director for direction, which is what I did in most cases.

MR. WOLFE KC: You were invited, in 2008 -- if I could have up on the screen, please, WIT-14769, paragraph 3. You were invited or asked by the Western Trust to assist with the review for them back, you think in 2008, and attended a training session on the framework which they ran for their staff. However, afterwards your assistance with the actual practical case of that review wasn't necessary, for whatever reason, so you didn't engage in the actual conduct.

# ONE DIRECTION – Ten Steps to Success

**Meaningful Job Planning for Consultants and SAS doctors working with the Southern Health and Social Care Trust**

**July 2018**

**R E R Wright**

Version 3

18th July 2018

DRAFT



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

**ONE DIRECTION -10 steps forward**

Meaningful Job planning for Consultant and SAS doctors working with the Southern Health and Social Care Trust

**Context**

Since the introduction of the 2003 Consultant Contract a regular annual job plan review has been recommended to maximise opportunities for the Trust and the doctor to work together to provide effective patient care. Participation in the process is both a professional and contractual obligation. Job planning in NI has traditionally been based upon a number of key documents such as the *Step by Step guide for Consultants in Northern Ireland*- BMA(Last updated June 2016) , BMA *Job planning for Staff and Associate Specialist and Specialty doctors: Introduction* (Last updated February 2017). In addition The Southern HSC Trust recently commissioned an internal Audit of the Job Planning process, *SHSCT-Management of Consultant Medical Staff 2017/18* (April 2018) which has highlighted a number of areas for improvement. Within the UK NHS Improvement has produced a highly relevant paper entitled *Consultant Job planning: a best practice guide* (July 2017).

In addition, the SHSCT is keen to improve the delivery of the job planning process and the effectiveness relevance of job planning for both the doctor and the Trust. This paper incorporates the best practice described in these papers, outlining specifically how the Trust will address the job planning challenges over the next few years keeping the delivery of care to our patients and clients as its main focus. It will also address the specific terms of reference set out below as outlined by the Chief Executive.

**Terms of Reference**

1. Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust , the Doctor's and most importantly the patients' needs
2. Improved compliance with internal Audit job planning recommendations
3. Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention
4. Sustainability of process

**Methodology**

A review of the current relevant published documents as outlined above was undertaken. Note was taken of views expressed at the job planning review group together with individual discussions with a range of AMDs CDs Ads Directors and Medical HR staff.



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**Principles underpinning the job planning process**

- The job plan should be developed in a spirit of partnership
- It should be a prospective agreement setting out duties, responsibilities and objectives
- It should cover all aspects of professional practice
- It may be modelled wholly or partly on the previous year's plan
- The plan may be wholly or partly be team based
- It should include local, regional or national objectives
- It should include personal objectives
- Resources and support required are agreed and stated
- The process is separate from, but linked to appraisal

**Current Trust Position**

The job planning process and guidance will ideally be approved in conjunction with the BMA Local negotiating Committee (LNC) in the spirit of collaboration and mutual respect. It is important to create the right climate by adopting a non-threatening partnership approach rather than a coercive one. Trust job planning guidance should be applied fairly and consistently. The current updated guidance is with LNC for consideration at present. This process may take several months, however this should not hold up further improvements to the job planning process as outlined below.

An active process of engagement with AMDs , CDs ,Ads and medical staffing is ongoing in a bid to drive the current years job planning process as far as is possible within the current system and good progress is being made with a high level of engagement.

**Job Planning and Appraisal**

Although job planning and medical appraisal inform each other, they should be separate processes. Doctors have told me that they currently feel a disconnect between the two processes. The previous doctors' appraisal should be made available to the Clinical Director(CD) or other job planner who should be aware of the contents and in particular the Personal Development plan (PDP) prior to the JP meeting. This will require cooperation between the appraisal team and the medical workforce job planning team, however, the introduction of the new on line doctor appraisal system in 2018 should make this technically much easier with only minimal additional administration time. It is a shared responsibility of the job planner and the individual doctor to bring relevant appraisal issues to the job planning discussion

- **Recommendation 1 The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan**



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**Making Technology Work**

- In order to minimise the administrative burden, effective use of electronic and digital systems should be available in line with best practice. This Trust already utilises the *'Allocate'* (formerly *Zircadian*) system. This is the most common system used for this purpose in the UK. A number of suggestions for further improvement have come from the Associate Medical Directors (AMD) Job Plan review group which have been partly implemented. This programme of improvement should continue. Already this year significant training opportunities have been provided from the supplier and the in house medical management scheme.
- Discussion with AMDs, ADs (Associate Directors) and CDs (Clinical Directors) has suggested that there is limited added value in having a third 'sign off' often at Director Level. The current three stage system presents the opportunity for unnecessary delays in the sign off process. There is acknowledgement that service directors need an assurance about the process, but the consensus was that this could be better facilitated in the form of directorate reports that could be provided by the medical staffing /*Allocate* team on a regular perhaps twice yearly basis.
- There was consensus that it would be useful for the *Allocate* system be set up to send systematic email prompts to both the doctor and the CD in advance of their sign off date and when a JP is overdue.

***Recommendation 2.*** ***The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.***

***Recommendation 3.*** ***Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories.*** **'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates**

**Making Job Planning a prospective annual process**

- The recent internal Audit clearly demonstrates that currently a significant percentage of doctors do not have an annual job plan review and that it is often retrospective rather than prospective rendering the process less meaningful. Acknowledgement needs to be given to increasingly complex patterns of working such as the 'consultant of the week' model.

- Linking the job planning cycle to the Trust's business planning cycle would be helpful in aligning organisational objectives and would make it easier to predict when job planning should occur. Flexibility will need to be given to job planners (CDs and AMDs) within their own job plan to allow intense periods of job planning activity at certain times of the year.



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

Whilst work continues currently to deliver the 2018 JPs, to ensure Job plans are in place PROSPECTIVELY for April 1st 2019 the following cycle should be implemented. This is based upon the *NHS Improvement* paper entitled 'Consultant Job planning: a best practice guide (July 2017).'

Quarter 2- July – September
Clinical director sends out preparation for and invitation for job plan review, giving 6 weeks notice. Appraisal documentation shared with CD.

Quarter 3 October to December
Team Job planning meeting to discuss and agree objectives, SPAs and any required rota changes. CD, Associate Directors, Service Managers Consultants and SAS doctors present.
JPs entered on Allocate by 31st December allowing 3 months for mediation/appeal if required.
JP consistency team (See later) check a proportion of JPs for consistency and fairness

Quarter 4 January to March
Mediation and/or appeals

Quarter1 April to June
Job plan effective 1 April

**Recommendation 4 The directorates should implement a systematic, timely prospective process similar to that outlined including team meetings with doctors CDs Ads and Service managers within quarter 2**

**When a job plan is not agreed**

Consultants are expected to engage in the annual job planning process; failure to do so could constitute one of the grounds for deferring pay progression for the year in question. Doctors however should NOT be penalised for failing to meet objectives for reasons beyond their control. Both employers and consultants have a responsibility to identify potential problems with achieving objectives as they emerge rather than waiting for an annual job plan review meeting.
Where a job plan is not agreed because it is in dispute, the doctor should not suffer any detriment whilst a potential mediation or appeals process is progressed. The informal process of facilitation with a third party as outlined in the terms and conditions of the consultant contract. Experience in this cycle has shown that this is can be an effective means of achieving resolution of difficult issues.
Formal appeal may considered by either party if facilitation is unsuccessful.



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**Medical Job Plan Consistency Committee**

A proportion of job plans (as high a percentage as practical) should be reviewed by a committee to ensure Trust job planning guidance is being followed with a consistent and fair approach.

*Membership*

The committee should consist of a Medical Director representative, Associate Medical directors, human resource medical staffing representative, and relevant CDs as required .

*Purpose*

To ensure consistency and an even handed approach across the Trust. It is NOT a mediation or appeal forum.

**Recommendation 5 A Medical Job Plan Consistency Committee should be established reporting to the job planning lead (see later)**

**Making Job plans Competitive and Attractive**

- Doctors should understand what is expected of them by the Trust and know they are being treated fairly with other team members.

- Job plans should contain an agreed baseline of commitments detailing attendance and activity expectations for the year ahead. These should be transparently reviewed and agreed, and be clearly documented for future reference. Activity expectations should be based on a minimum of 42weeks in the working year. A job plan covers the whole of the week, including – where relevant – weekends and nights (to ensure consistent delivery of high quality patient care).

- Supporting professional activities (SPAs) underpin direct clinical care and should be linked to clear objectives. The Academy of Medical Royal Colleges estimates that 1 to 1.5 SPAs per week are the minimum for a consultant's continuing professional development (CPD) for revalidation purposes. The Trust supports this view. Additional SPAs may be awarded for specific responsibilities or duties by agreement . There is a view held by many Trust doctors that currently the SHSCT average SPA allocation is lower than other comparable Trusts within Northern Ireland. Our current average SPA allocation is currently 1.68 PA for full time consultants only. The range is from 0.375 PA to 2.75 PA …… and our current non DCC PA ( Including SPA, APA and other external duties) allocation average is 2.52 PAs

  It is my view that given the current recruitment and retention difficulties it would be worth guaranteeing each new consultant a minimum of 2.5 SPAs at the time of appointment and 1.5 SPAs for SAS doctors at the time of appointment, both for a period of 3 months initially during which time there would be a job plan review. This would facilitate induction for new staff and would be an attractive package for recruitment and would solve the increasing difficulties we are having in getting new job plans approved by the Royal Colleges because of



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the SPA issue. After 3 months the SPA allocation could be reduced to 1.5 and 1 SPAs for Consultants and SAS doctors respectively with additional non clinical Pas (SPA/APA) agreed locally for specific roles. Such measures would be likely to have an immediate impact on recruitment if jobs were explicitly advertised with this on offer. We already offer an average of 2.52 non clinical Pas to all other consultants. Ideally We should work towards reducing the range so that most consultants can expect 2.5 non clinical SPAs made up of SPA and APA

Currently full time SAS doctors receive an average SPA allocation of is 1.55 PA across the Trust with a range is from 0.75 PA to 2.00 PA
In line with our ambition of developing SAS doctors we should consider working towards an allocation of 1.5 SPA

This would help to imbed the Consultant and SAS group as valued staff members, would be transparently fair and would allow the CD share much of the current administrative burden around the team. It would be consistent with the principles of the *HSC leadership strategy 2018* by encouraging leadership roles at the coal face and could be used creatively to move forward major pieces of project work as required by the Trust. In my view such a move would send a powerful message to potential job applicants that this organisation is a good place to work for doctors.

**Recommendation 6 Move to a position where each new consultant receives a minimum of 2.5 at initial appointment and 1.5 for SAS Doctors.**

- *Flexibility of SPAs in relation to off site working*

There is a growing awareness that within NI some Trusts offer some flexibility about a proportion of their SPAs being worked off site. Within our own Trust this already offered in some departments. The AMD job plan JP review task force have reviewed this issue and have accepted this has some value when appropriately managed. This as yet is not widely implemented.
It is my view that all doctors should be offered the opportunity of working up to 1 SPA off site as long as they can evidence the work they have done through the appraisal process. A number of parameters would need to be understood by all. For instance, the doctor would need to remain available to be called on site should an emergency arise and that their annual appraisal needs to show that their CPD requirements are being met. These parameters have been clearly outlined within the Draft Trust Job Planning guidance document.

**Recommendation 7 The Trust should offer the opportunity to every doctor to work 1 Core SPA off site.**

- *Emergency on call for senior doctors*

There is a growing body of evidence to show that emergency on call work becomes more problematic for a doctor as they grow older associated with increasing stress. There is also a



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body of evidence that shows an increase in the number of adverse incidents related to out of hours working as doctors grow older. This is increasingly stated as a factor contributing to early retirement for doctors. In my view each team should consider the minimum number of doctors required to provide a sustainable out of hours on call service with a clear indication that older doctors have a reasonable expectation of coming of the on call rota prior to the normal retirement age. Teams would then be able to forward plan for service provision on this basis. It is my belief this would help retention of staff in the long term.

**Recommendation 8. The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale**

- **Sustainability**

A job planning lead should be appointed for the Trust with clinical credibility. This could be similar to the current appraisal lead as a stand alone post or possibly as one of the roles of a deputy medical director with 1 PA time allowance to oversee and coordinate the job plan process. Their roles and responsibilities would include potential challenge to AMDs over process and would and include a reporting remit to SMT and Trust board. In order to support this role and facilitate the job planning administration team within medical HR it is likely that some additional administration support will be required for this team. The medical HR team believe a full time band 4 post would be appropriate to cover the workload and proactively manage the system

**Recommendation 9**

**A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis. This should be supported with appropriate administrative resource within medical HR staffing**

- **Ongoing Oversight**

A Senior Job Planning Oversight Committee (JPOC) should be established perhaps meeting quarterly to oversee progress and strategic direction. It would receive reports from the Job Planning lead and consider suggested changes to the job planning guidance. It would consider implications of any potential changes to the consultant contract and take note of new best practice guidance from relevant national or regional bodies.
It would be chaired by the Medical Director and include the Director of HR, Finance Director and Operational Directors. It could be supported by an AD from the Medical Director's office

**Recommendation 10**

**A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT**

**Conclusion**

The above report has considered current best practice recommendations and the issues raised within our recent internal audit report related to Trust Job Planning. It has considered



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the Terms of Reference outlined by the Chief Executive and made 10 major recommendations to address the issues raised.

TOR 1

**Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust, the Doctor's and most importantly the patients' needs.**

The new easy to understand job planning timetable aided by a simplified allocate prompt and sign off system will allow JPs to be agreed prospectively rather than retrospectively. The Job Planning lead will drive the process forward with fairness ensured by the consistency committee resulting in an open and transparent process. The formal link to appraisal and agreed objectives will enhance both the JP and appraisal systems

TOR 2

**Improved compliance with internal Audit job planning recommendations**

As above. The JP lead will report regularly to SMT and through them to Trust Board on behalf of the Medical Director resulting in direct accountability for the process. The simplified process will ensure timelier processing of JPs. The Consistency committee will ensure that JP principles are adhered to.

TOR 3

**Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention**

The enhanced commitment to Non DCC time is likely to have a positive effect on recruitment and retention whilst ensuring that important roles required by the Trust are fulfilled.
Offering 2.5 SPAs to all new start consultants would be a powerful recruitment tool.
A more flexible approach to limited off site SPA time is potentially a decisive factor in doctors making a choice between prospective employers.
The commitment to link appraisal agreed objectives to the JP process will further demonstrate how the Trust values its staff.
The reasonable expectations for older consultants to withdraw from the on call rota in a planned and coordinated manner is likely to assist with retention as this has been raised as an issue by leaving doctors at their exit interviews

TOR

**Sustainability of process**

The appointment of a clinical lead to drive the process and the establishment of the Job planning oversight committee together with the changes to the cycle and sign off process should ensure sustainability and deliverability over the next few years.



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**Summary of Recommendations (10 Steps to success)**

**Recommendation 1** The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan.

**Recommendation 2** The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.

**Recommendation 3** Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories. 'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates.

**Recommendation 4** The directorates should implement a systematic, timely prospective process as outlined including team meetings with doctors ,CDs Ads and Service managers within quarter 2

**Recommendation 5** A Medical Job Plan Consistency Committee should be established reporting to the job planning lead

**Recommendation 6**

Move to a position where each new consultant receives 2.5 SPA and 1.5 Spa for SAS doctors at the time of appointment. An early job plan review should then determine the need for any non clinical Pas above 1.5 and 1 respectively

**Recommendation 7** The Trust should offer the opportunity to every doctor to work 1 flexible SPA off site.

**Recommendation 8**

The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale

**Recommendation 9**

A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis

**Recommendation 10**

A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT



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leadership and segway into the developments that have taken place, and we touched upon them briefly yesterday, but the developments that have taken place in respect of medical professional governance. And here I want to explore with you issues including job planning, appraisal and re-validation, and steps that have been undertaken within the Trust to try to challenge and get to grips with what might be described as idiosyncratic clinical practice. 11:00

Starting with the general, I suppose. 11:01

I wonder do you acknowledge or see that the evidence before the Inquiry suggests that, at least in part, the medical professional governance system hasn't worked as effectively as it should have done historically. It might be said that in terms of appraisal, work planning, revalidation, there was often slippage. Perhaps the right ingredients or the right information wasn't being brought to bear and those valuable professional governance tools were left underdeveloped? 11:02

A. Yes, I agree with that. I think that there was - there's a very good electronic system in the Trust for job planning, but it requires the information to be put in, agreed, and then signed off. So certainly the mechanism for undertaking job planning was there, but I'm not sure that it was adhered to very seriously at times and, you know, that led to problems in terms of, you know, sign off, payments, understanding what people's roles and responsibilities were. 11:02

I also think that one of the shortcomings in job planning as it's constructed currently is that it focuses on activity rather than quality and safety, and that's a missing element of it. So I mean one of the things that I have been starting to think about recently, along with the Medical Director and others, is: How do you build quality and safety into a job plan, not just activity? That's really important. Because, you know, what should flow from that then is the appraisal system. And, again, in Southern Trust my sense was that on the face of it there was a system of appraisal in relation to, you know, and in particular good managers in there who ran the appraisal system, but actually in terms of the engagement of doctors with it and engaging with the spirit of it, I'm not sure that that was as fully engaged with as it needed to be. So it was difficult, I think, for people who hadn't got signed job plans, and particularly job plans that don't mention safety and quality, to then be appraised against that, when actually the four domains within appraisal concentrate on that mostly rather than, you know, activity which tends to be what the job plan is about. So the read across, regardless of Southern Trust, I think isn't robust, and then within all of that, in terms of how the appraisal system is used, I think was at times superficial. And the thing that...

11:03 11:03 11:04 11:04 11:04

51 Q. Just...

A. Sorry.

# Appraiser Clinic

[redacted]

September 2013

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Objectives

- To update you on the local revalidation process and share the resources available to support you
- To discuss the new regional appraisal documentation and guidance
- To advise you on collating supporting information of sufficient quality, volume and breadth to reflect your whole practice

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Programme Outline

- Session 1 – Revalidation - support available within the Trust
- Session 2 – New Appraisal Doc[redacted] – main differences
- Session 3 – Supporting Information – advising appraisees/dealing with insufficient information

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# What is Available - Website

- Supporting Information for Appraisal
- Appraisal scheme and forms
  - Aide memoire and QA tool
- Appraisal Training and awaren[redacted]
- Revalidation resources
  - SRTs
  - CLIP reports
  - Links to PCF systems
  - Study Leave summary
  - Guidance on CPD
- Useful Links
  - Mandatory Training – Training Passport
  - Revalidation Newsletters Trust + GMC
  - Royal Colleges

www.southerndocs.hscni.net

Irrelevant information redacted by the USI

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# SHSCT Revalidation Support Team

- Dr Joan McGuinness, Corporate Lead for Appraisal and Revalidation
- Dr Damian Scullion, Consultant Lead for [redacted] Revalidation
- Dr Rosemary Black, SAS Doctor Lead for Appraisal and Revalidation
- Anne Brennan, Senior Manager, Medical Directorate
- Norma Thompson, Project Manager, Medical Directorate

[redacted]

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# NI Implementation Plan

*Dec 2012- March 2013*: All Responsible Officers and some medical leaders will revalidate

*April 2013-March 2014* : 20% of doctors rev[redacted]

*April 2014- March 2015* : 40% of doctors revalidate

*April 2015- March 2016* : 40% of doctors revalidate

*April 2016- March 2017*: Any remaining doct[redacted]alidate

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# NI Implementation Plan

Allocation of dates will be by **penultimate** digit of GMC registration number. These have been randomly selected and are:

Year 1* April 2013-March 2014 : **4, 8** [redacted]

Year 2 April 2014- March 2015 : **1, 2, 5, 6**

Year 3 April 2015- March 2016 : **0, 3, 7, 9**

* ROs will allocate to quarters for Year 1, and yearly thereafter. GMC allocate actual revalidation date. [redacted]

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# Revalidation Recommendation

- A positive recommendation that a doctor is up to date and fit to practise
- A request to defer the date of [redacted] recommendation
  - Collect supporting information
  - Completion of investigation process
- A notification of the doctor's non-engagement in revalidation. [redacted]

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# Readiness for 1st Cycle

- **Participate** in annual appraisal based on GMP and covering whole practice [redacted]
- **Completed** and signed off one appraisal
- **Collected and reflected** on specified Supporting Information [redacted]

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# Appraiser Role

- Work with individual doctor to:
  - support their development
  - prepare them for revalidation
- Responsible Officer Assurance [redacted]
  - Co-ordinate their doctors' appraisals in line with the organisation's processes including sign-off
  - Sufficient supporting information
  - Appropriate challenge to poor practice and behaviour
  - Meaningful Personal Development Plan [redacted]

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# Doctors Role

- Participate fully in appraisal
- Identify an appraiser and schedule appraisal meeting (directory of appraisers)
- Prepare for the appraisal meeting and make the appraisal folder available to the appraiser at least 10 working days in advance
- Agree personal objectives, actions and personal develo[redacted] the coming year
- Identify factors that may inhibit performance
- Prepare supporting information for revalidation with GMC
- Seek to achieve defined objectives and fulfil individual learning and development plan.
- Complete form/s clearly written and legible.
- Inform the appraiser of any performance or professional issues.
- Send the signed originals of all Forms 1 to 7 to the Medical Director's Office, Clanrye House, DHH, along with Appendix 2 Ap[redacted]eedback Form

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# Trust 3 Stage Process

- Every doctor's appraisal/PDP documentation will be quality assured by [redacted] RST
- Before revalidation:
  - Meet with RST member
  - Final sign off with Medical Director
  - Recommendation made to the GMC [redacted]

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# Appraisers - Competency

- Professional Responsibility
- Knowledge and understanding
- Professional judgement
- Communication skills
- Organisational skills

[redacted]

[redacted]

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# Key Process Elements

- Matching Doctors to Appraisers
- Appraisal Cycle and Timeframe
- Support contacts
- Participation in Appraisal
- Quality Assurance
- Documentation and Guidance

[redacted]

[redacted]

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# Participation in Appraisal

- 100% needed including **Locums**
- Appraisers – co-ordinate their "patch"
- Appraisees collate portfolio and sub [redacted] appraiser
- Alert MD to immediate issues + general briefing at end of appraisal cycle
- Report on process to Chief Executive Officer

[redacted]

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# Quality Assurance

- Appraiser / Doctor surveys
- Portfolio Audit
- Evaluation:
  - of training
  - of appraisers
  - of system
- External  Quality Assurance
  - RQIA – clarify arrangements

[redacted]

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# Appraisal Meeting - Appraiser structured reflective template

Requirement: Annually

| Name of Appraiser: | GMC No: |
|---|---|
| Number of Appraisal Meetings Conducted: | |
| What were the key learning points? | |
| What areas do I need to develop? | |
| I agree that the information contained within this form can be collated and used anonymously to assist with audit requirements.<br><br>Name: Date:<br><br>Job Title: | |

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# New Documentation [redacted]

[redacted]

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# New Documentation

- **Form 1** - Background Details
- **Form 2** - Current Medical Activities
- **Form 3** - Supporting Information & [redacted] Appraisal Discussion
- **Form 4** - Personal Development Plan
- **Form 5** – Health & Probity
- **Form 6** - Sign Off
- **Form 7** – Revalidation Progress [redacted]

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# Main Differences

## Previous documentation

- Based on 7 areas of GMP
- Form 3 = evidence and previous PDP review
- Form 4 = appraisal summary + PDP
- Had forms 5 & 6 which were rarely used

## New documentation

- Based on 4 domains
- Form 3 = supporting information + summary of discussion
- Form 4 = rev[redacted] PDP and new PDP
- Health and Probity statements part of documentation
- Sign off form = mitigating circumstances + summary of GMC supporting information
- Form 7 = tra[redacted]ess towards revalidation

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# Key Points


- Emphasis is on whole practice appraisal.
- 2.5 – private work within the Trust
- 2.6 – details of independent sector practice
- 2.7.4 eg medical legal work

[redacted]

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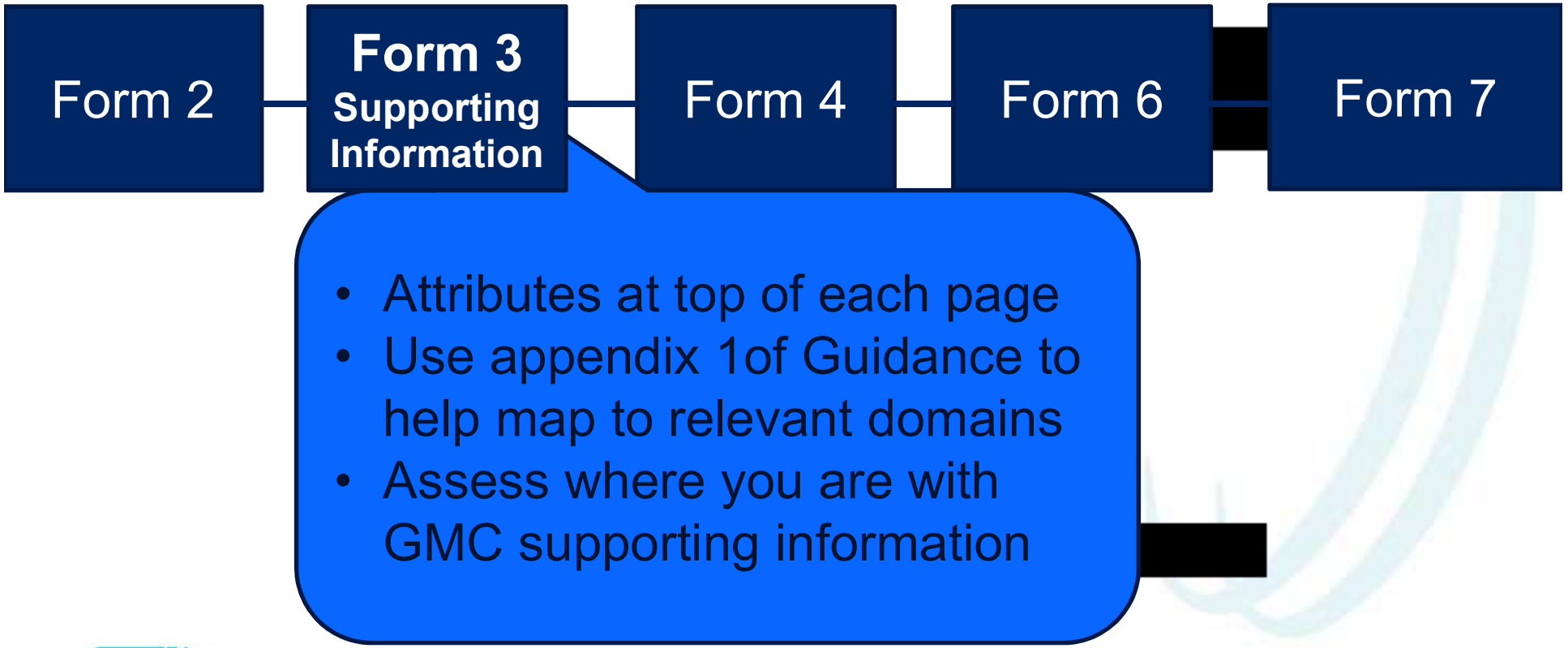
# Key Points

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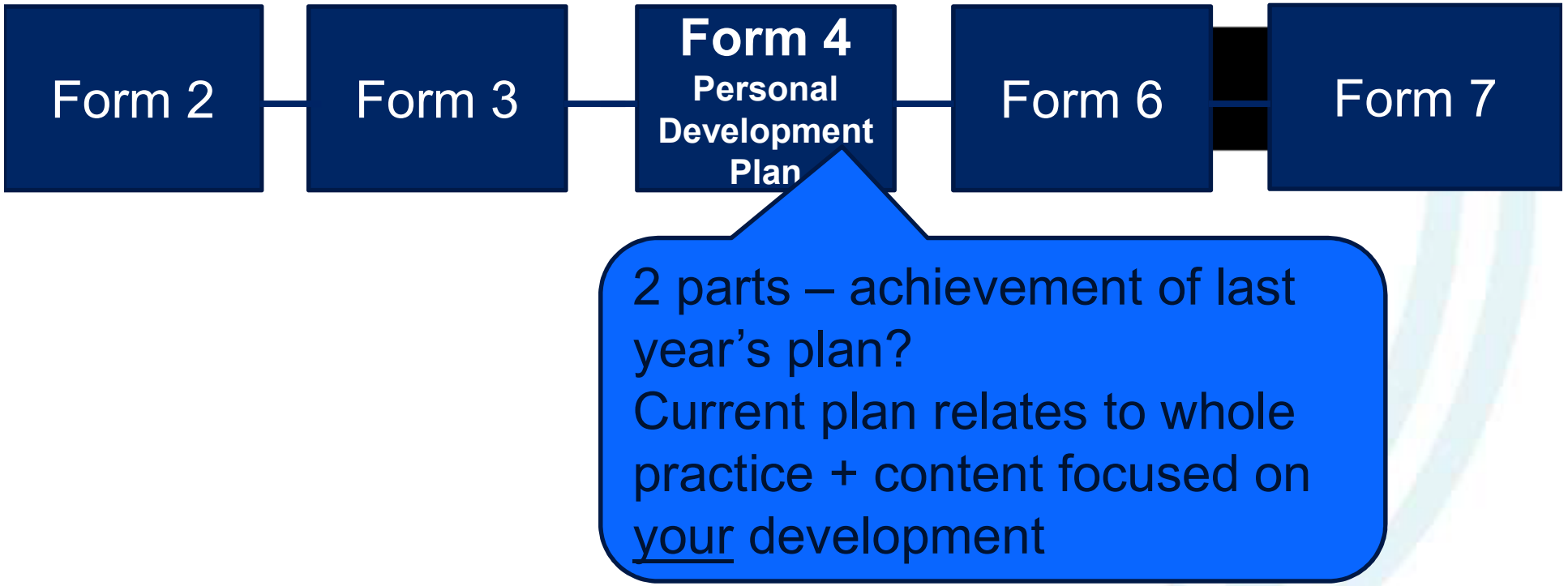
# Key Points

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# AMRC CPD Guidance

- Scope of Practice
- Reflection and Outcomes
- How needs have been identified
- Balance of CPD activities
- Time/resources/special circumstances

[redacted]

[redacted]

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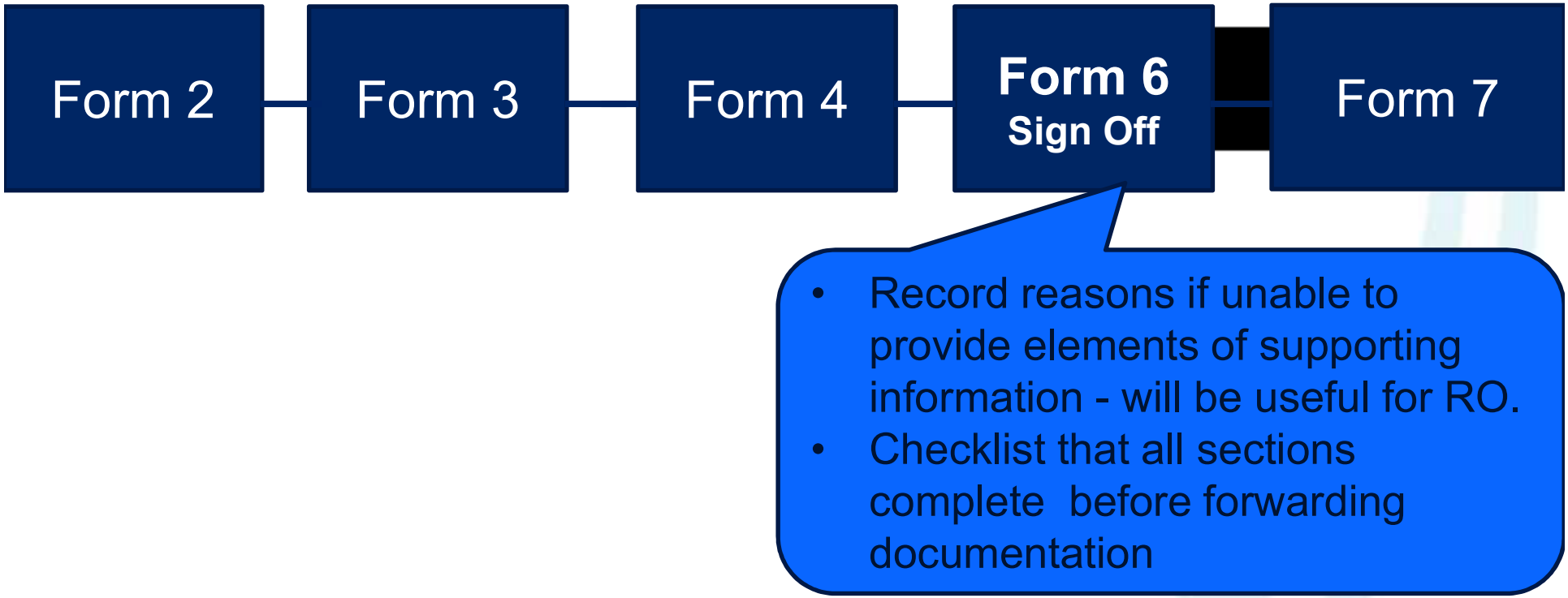
# Key Points

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# Key Points


- Summary over 5 years to show a)annual participation and b)meeting GMC requirements – start at year 1
- Important for RO when making revalidation recommendation

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# Session 2

## Supporting Information

[redacted]

[redacted]

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# Session Outline

- GMC Supporting Information requirements
- Colleague and Patient feedbac[redacted]
- Mapping information to GMP a[redacted]
- Assessing supporting information

[redacted]

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# Supporting information for appraisal and revalidation

General Medical Council

Regulating doctors
Ensuring good medical practice

During their annual appraisals, doctors will use supporting information to demonstrate that they are continuing to meet the principles and values set out in *Good Medical Practice*.

This guidance sets out the supporting information that you will need to provide at your annual appraisal and the frequency with which it should be provided. It also gives further details on how the information can be used or discussed during appraisal.

All doctors, regardless of the nature of their practice, should be able to meet these requirements although the underlying information may differ in certain categories depending on your practice and the context in which you work.

## Supporting information

The supporting information that you will need to bring to your appraisal will fall under four broad headings:

- General information – providing context about what you do in all aspects of your work
- Keeping up to date – maintaining and enhancing the quality of your professional work
- Review of your practice – evaluating the quality of your professional work
- Feedback on your practice – how others perceive the quality of your professional work

There are six types of supporting information that you will be expected to provide and discuss at your appraisal at least once in each five year cycle. They are:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Review of complaints and compliments

The nature of the supporting information will reflect your particular specialist practice and your other professional roles. For example, an appropriate quality improvement activity will vary across different specialties and roles.



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# General Information

- Personal details - GMC number
- Scope of work
- Record of annual appraisals
- Personal development plans + reviews
- Probity statement
- Health statement; registration with GP; immunisation

[redacted]

[redacted]

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# Supporting Information

- Continuing professional development
- Quality improvement activity
- Significant events
- Feedback from colleagues
- Feedback from patients (where applicable)
- Review of complaints and compliments

[redacted]

[redacted]

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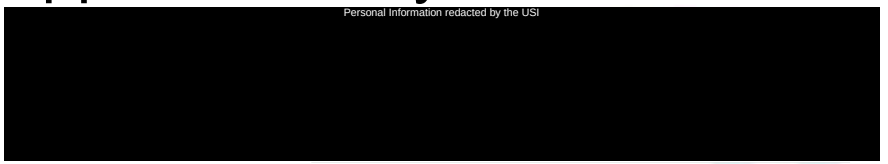
# Keeping Up To Date - CPD

- Covers whole scope of practice
- Clear links with PDP
- Focus on outcomes rather than time
- Links to current and future roles
- **Required annually and covers 12 months prior to appraisal**

- A summary report of approved study leave at




- CPD Guidance
- Personal Development Plan (PDP) Structured Reflective Template
- 'Training Passport' which will summarise [redacted] details of training you have participated in

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# Review of Practice

- Quality Improvement Activity – considered at each appraisal
  - Clinical audit; review of clinical outcomes; case reviews; teaching activities; improvement projects
  - Evaluate and reflect on results; take action; what is the outcome – improvement or maintenance of practice

- Consultant Level Indicator Programme [CLIP] reports are available annually to doctors who have recorde[redacted] hospital PAS[redacted]
- A guide for CLIP reports is available to download. CLIP Guidance
- Record of attendance at Medical Morbidity/Mortality meetings
- Structured Reflective Templates on Data Collection and Case Review

HSC Leadership Centre

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Review of Practice

- Significant events – required annually
  - participation in meetings to discuss incidents
  - Lessons learnt; preventative actions
- Can use team based information with reflection on your practice

- A report extracted from the Trust Datix incident management system has been forwarded to you.
- A Structure[redacted] template is [redacted] assist you in demonstrating reflection/learning from incidents

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Feedback on Practice

- Complaints and compliments – review required annually
- Awareness of numbers and procedures
- Participation in investigation and response
- Actions taken – individually or team
- Use structured reflective template

- A report extracted from the Trust Datix complaints management system has been forwarded to you.
- A Structu[redacted] template is available to assist you in demonstrating reflection/learning from complaints.
- There is also a template regarding [redacted]ce of complaints.

HSC Leadership Centre

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Complaint report structured reflective template

Requirement: one for each complaint you have received.

| |
|---|
| Name of doctor: GMC No: |
| Date of complaint: |
| Nature of complaint: |
| Status of complaint: On-going / resolved |
| Involvement of other bodies: Responsible organisation / GMC / Other |
| If resolved, what were the findings? |
| How will my practice change? |
| Final outcome after discussion at appraisal:<br>(Complete at appraisal considering how your outcome will improve patient care) |

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Patient and Colleague Feedback

[redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Issues + Tips

What advice would you give an appraisee:

1. No patients
2. Low numbers of patients within [redacted]
3. Specific specialties eg Pathology
4. No-one to help with distribution
5. Patient issues eg language; bad news; rush out after clinic [redacted]

HSC Leadership Centre

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# GMP Framework – Feedback from Patients

| Knowledge, Skills & Performance | Safety & Quality | Communication Partnership & Teamwork | Maintaining Trust |
|---|---|---|---|
| Maintain your professional performance | Put into effect systems to protect patients and improve care | Communicate effectively | Show respect for patients |
| Apply knowledge and experience to practice | Respond to risks to safety | Work constructively with colleagues and delegate effectively | Treat patients and colleagues fairly and without discrimination |
| Keep clear, accurate and legible records | Protect patients and colleagues from any risk posed by your health | Establish and maintain partnerships with patients | Act with honesty and integrity |

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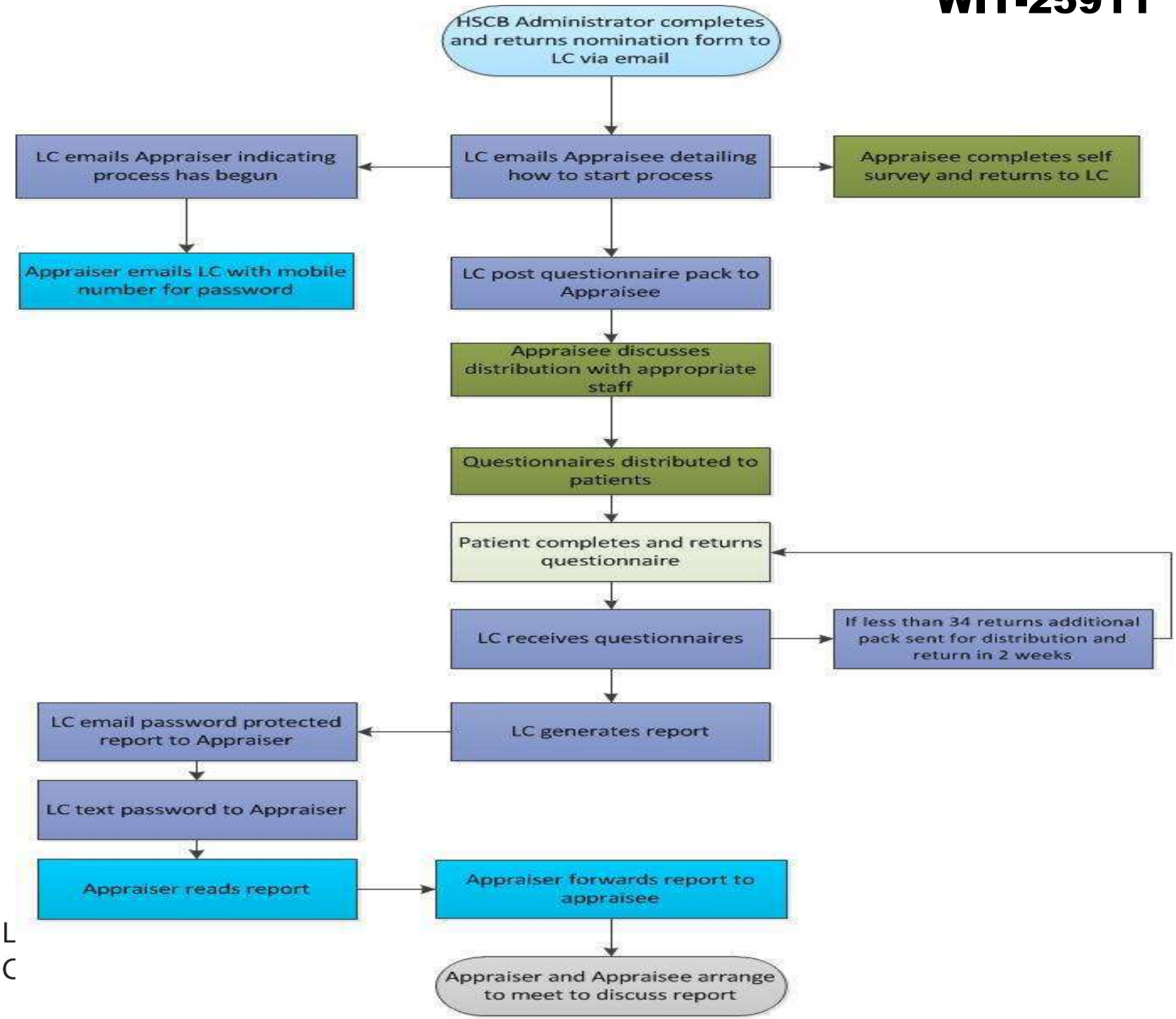
Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.




Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Patient Feedback Report

- Section 1: Respondent Profile
- Section 2: Question Ratings:
  - Q5 – 7 parts rated on 5 point scale
  - Q6 – 2 questions Disagree – Agree scale
  - Q7 – 3 statements  Yes/No
- Section 3: Patient Comments
- Section 4: Summary Graphs by Question
- Section 5: Benchmark Data

[redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Colleague Feedback Process

- Background;
  - Colleague feedback system since [redacted]
  - Updated June 2012
  - To date 200 completed; over 300 in progress
- Colleague – respondents
  - 20 distributed; 15 required
  - 50/50 medical; non-medical [redacted]

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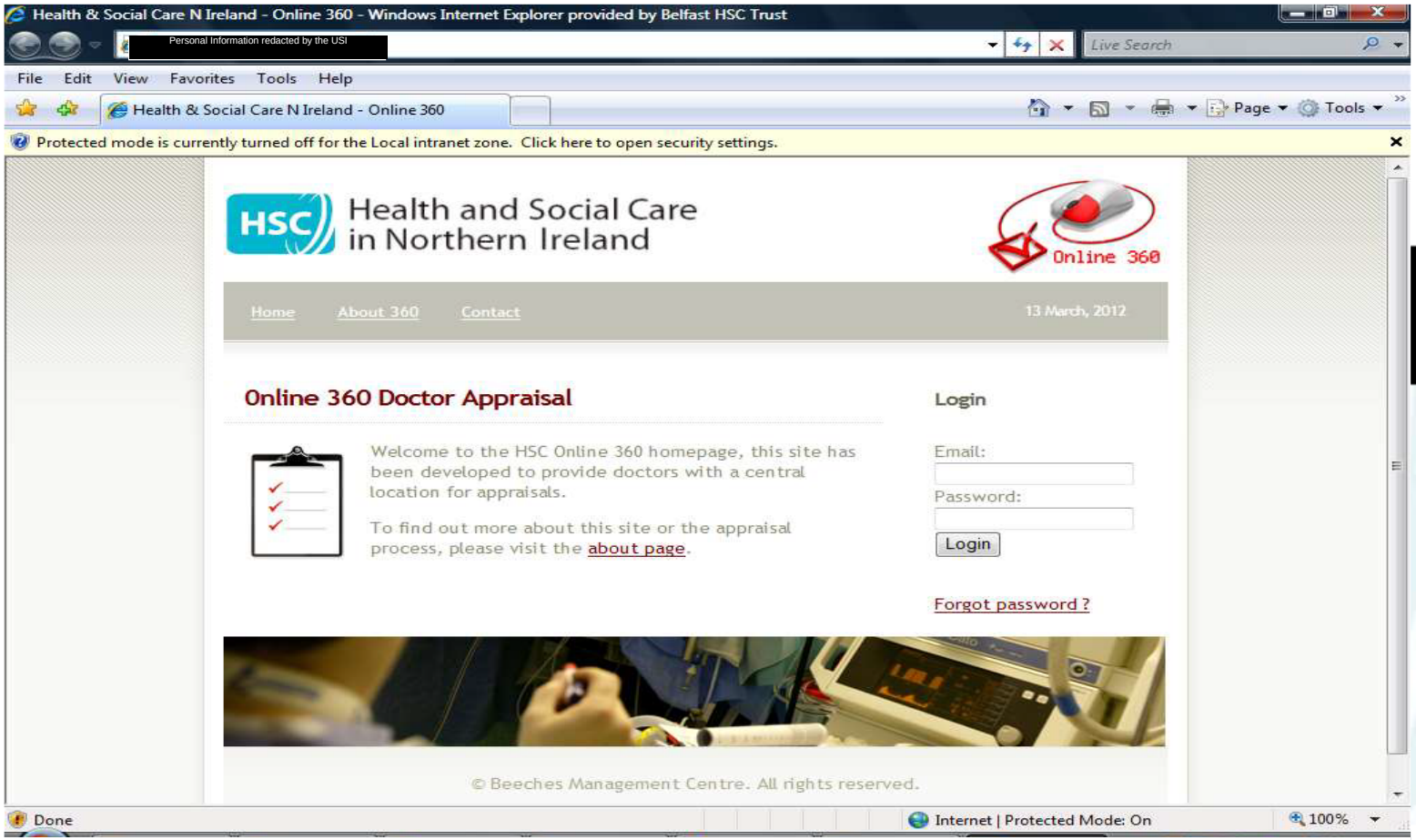
Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Colleague Feedback c5

## HSC Leadership Centre Tool




HSC Leadership Centre

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

Slide 43

c5 this slide is in twice (26 and 40)
cmcma014, 12/11/2012

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# GMP Framework – Feedback from Colleagues

| Knowledge, Skills & Performance | Safety & Quality | Communication Partnership & Teamwork | Maintaining Trust |
|---|---|---|---|
| Maintain your professional performance | Put into effect systems to protect patients and improve care | Communicate effectively | Show respect for patients |
| Apply knowledge and experience to practice | Respond to risks to safety | Work constructively with colleagues and delegate effectively | Treat patients and colleagues fairly and without discrimination |
| Keep clear, accurate and legible records | Protect patients and colleagues from any risk posed by your health | Establish and maintain partnerships with patients | Act with honesty and integrity |

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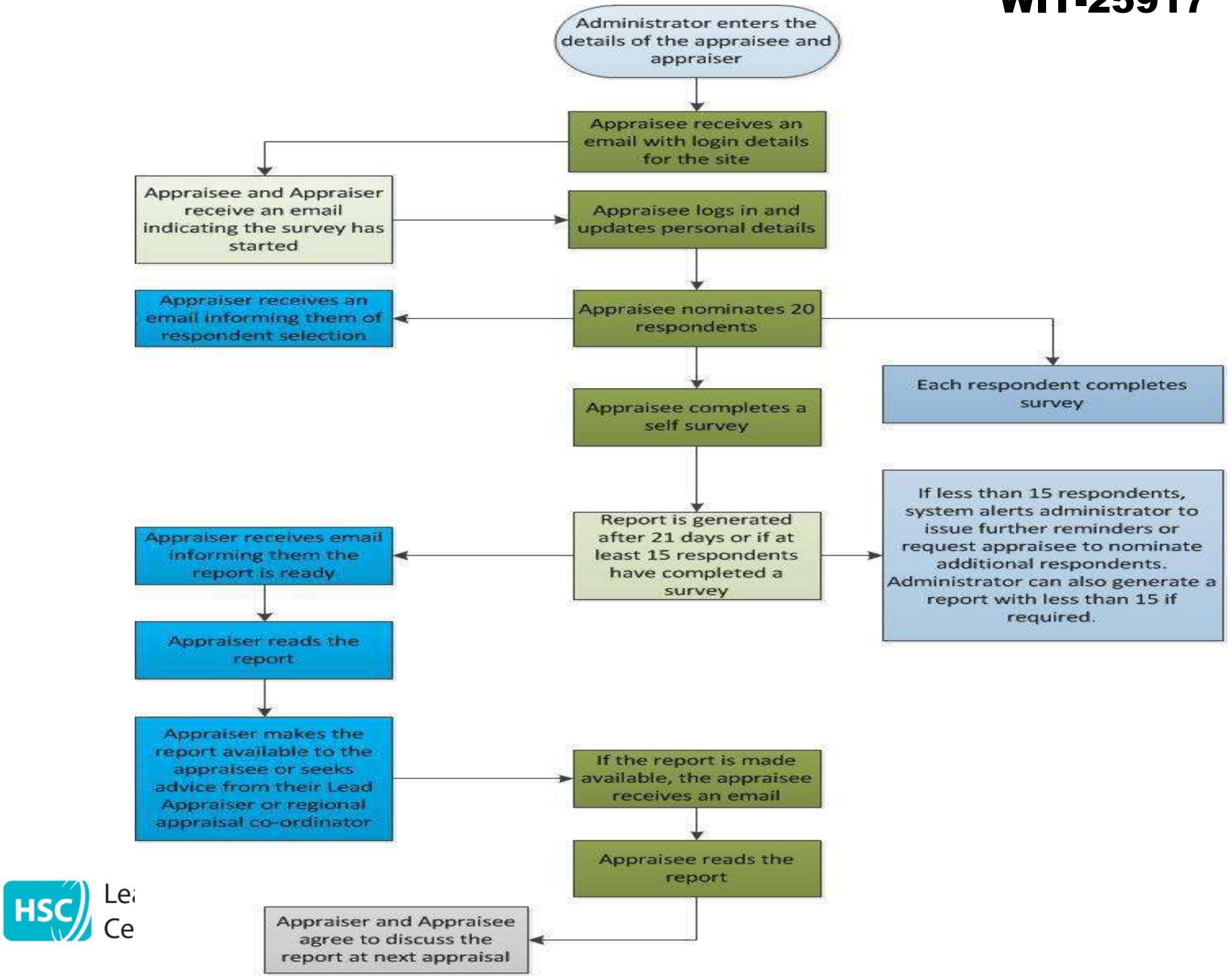
Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.




Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# The Feedback Report

- Cover page – respondent summary
- Section 1: Overall Summary
- Section 2: Written Comments
- Section 3: Summary Graphs by Question

[redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# MAPPING TO 4 DOMAI[redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# GMP Framework – Mapping Support Information to Domains

| 1.Knowledge, Skills & Performance | 2. Safety & Quality | 3. Communication Partnership & Teamwork | 4. Maintaining Trust |
|---|---|---|---|
| Colleague Feedback | Colleague Feedback | Patient and Colleague Feedback | Patient and Colleague Feedback |
| CPD | Quality Improvement Activity | | Complaints and Compliments |
| | Significant Events | | |

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# SHSCT Guidance

| Domain | Suggested Evidence/Supporting Information |
|---|---|
| **1 - Knowledge, Skills and Performance:**<br><br>**Attribute: 1.1 Maintain your professional performance**<br>**Attribute: 1.2 Apply knowledge and experience to practice**<br>**Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.** | • Job plan, workload records<br>• Evidence of how educational activity may have affected service delivery outcomes<br>• Information about teaching and training activities. Include any information in relation to delivering workshops and lectures, mentoring activities and tutorials undertaken.<br>• Evidence of reflective practice<br>• Evidence of CPD and audit activity<br>• Research activity<br>• Relevant process and outcome data<br>• Previous Form 4 and Personal Development Plan |
| **2 - Safety and Quality:**<br><br>**Attribute: 2.1 Contribute to and comply with systems to protect patients**<br>**Attribute: 2.2 Respond to risks to safety**<br>**Attribute: 2.3 Protect patients and colleagues from any risk posed by your health** | • Evidence of any resource shortfalls which may have compromised outcomes<br>• Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable)<br>• Reflection on significant events/critical incidents/near misses<br>• Records of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice<br>• Evidence of attendance at, and participation in, governance activity relevant to practice.<br>• Evidence of risk management to include near misses and action taken to addresses/reduce risks<br>• Evidence of registration with a GP, Statement of Health, vaccination records<br>• Statement of satisfactory research practice<br>• Records of training related to enhancing safety and quality of patient care<br>• Analysis of, and reflection on, current practice |

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# SHSCT Guidance

| Domain | Suggested Evidence/Supporting Information |
|---|---|
| **3 - Communication, Partnership and Teamwork**<br><br>**Attribute: 3.1 Communicate effectively**<br>**Attribute: 3.2 Work constructively with colleagues and delegate effectively**<br>**Attribute: 3.3 Establish and maintain partnerships with patients** | •<br>• Evidence of any team development activity<br>• Description of the team you work within (medical and/or multidisciplinary)<br>• Description of all activities in which you interact with other healthcare workers e.g multidisciplinary meetings, working groups and committee work.<br>• Analysis of trainee/medical student survey (where appropriate)<br>• Patient and colleague feedback<br>• Evidence of participation in multi-professional team meetings<br>• |
| **4 - Maintaining Trust:**<br><br>**Attribute:4.1 Show respect for patients**<br>**Attribute:4.2 Treat patients and colleagues fairly and without discrimination**<br>**Attribute:4.3 Act with honesty and integrity** | •<br>• Statement of Probity and Health<br>• Complaints<br>• Compliments<br>• Patient and colleague feedback. |

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Previewing Information

- Make arrangements to get information at least 1 week before appraisal
  - Is this the doctor's last appraisal revalidation? [redacted]
  - Use Supporting Information Guide to prepare for appraisal discussion

c7

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

Slide 51

c7 What is this?
cmcma014, 14/11/2012

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Supporting Information Guide

- **Sufficiency** – are all 6 areas of supporting information available?
- **Quality** – what level is the infor[redacted] currently at; where should it be?
- **Breadth** – Does the information cover the doctor's whole practice?

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

| Previous PDP | PDP Construction | Complaints | Audit | Significant Adverse Event | Colleague Multi Source Feedback | PatientMulti Source Feedback |
|---|---|---|---|---|---|---|
| **No achievements of the elements contained in the previous year's PDP** | A mention of developmental needs, evidenced with the information in Form 3 | Form 3 contains a simple statement on complaints | Simple data collection with no plan for change. | A record of event | NO - Statement | NO - Statement |
| **Only 1 achievement of the elements contained in the previous year's PDP** | Highlighted developmental needs, evidenced with the information in Form 3 | Form 3 lists the number of complaints | A simple audit against agreed standards. | Evidence that there has been discussion of the recorded events | YES - Statement | YES - Statement |
| **Evidence of good progress and reflection on the elements( up to 3) contained in the previous year's PDP** | Highlighted developmental needs, evidenced with the information in Form 3 and suggestions as to how they may be achieved | Form 3 lists and briefly describes each one | An audit that has led to practice review and re-audit. | Evidence that there has been discussion of the recorded events and that some actions have resulted from the discussion | YES – Document produced with reference to scores less than 3 and specific comments made. | YES – Document produced with reference to scores less than 3 and specific comments made. |
| **Full achievement of the elements and reflection on, contained in the previous year's PDP.** | Highlighted developmental needs, evidenced with the information in Form 3. In addition to how these needs will be achieved there is reflection on the impact of completion of objectives | Form 3 lists each complaint and there is consideration of each complaint including the outcome and potential changes that have occurred as a result. | An audit that has led to practice review and re-audit Learning and response to the audit results leads to a written reflection. Participation in a national audit. | Evidence that there has been discussion of the recorded events and that some actions have resulted from the discussion. Evidence that the resulting actions have been measured or appraised | YES – Document produced with reference to scores less than 3 and specific comments made. Linked to PDP where appropriate. | YES – Document produced with reference to scores less than 3 and specific comments made. Linked to PDP where appropriate. |

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Advice to Appraisees

What would you do if:

- Appraisee does not send information in advance of the meeting
- Arrives at the meeting with poorly organised information
- Key information missing despite previous conversations
- PDP from previous year not co[redacted]ed

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# Scenarios

1. Negative ratings on Patient feedback survey
2. Discrepancies between self and colleague ratings [redacted]
3. Discrepancies between the patient and colleague feedback surveys

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Personal Development Plans [redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Form 4 – Personal Development Plan

- Identify key development objectives for the year ahead
  - practical
  - achievable
  - defined outputs
  - agreed timescale
- Should address any gaps in supporting information which might impede reva[redacted]on

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Appraiser's Role

- Evaluate if doctor has achieved previous year's PDP
- Ensure that new PDP reflects w[redacted] practice and appraisal discussion
- Support doctor in identifying actions that suit learning preferences and available resources [redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Key Points

- Focus on whole practice
- Encourage use of SRTs
- Importance of PDP
- What to do if portfolio isn't up to scratch
  - Advice/awareness before appraisal
  - Advice re implications ie cannot sign off
  - Arrange follow up, preferably face-to face
  - RST members for advice

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

# Quality Assurance/Support

- All forms 1 to 7 will be quality assured by RST
- Complete Appendix 1Appraiser [redacted] Questionnaire and submit
- Complete SRT for own role as an appraiser

- What additional support/training would be helpful? [redacted]

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# Questions [redacted]

[redacted]

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Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

further part of this induction process, a short meeting is arranged for all new permanent medical staff with the Medical Director or Corporate Lead for Appraisal Revalidation during which various support initiatives are outlined to them i.e. the role of the Revalidation Team, the Trust's Medical Mentoring Scheme, the availability of the opportunity to job-shadow a non-clinical manager for a half day and the various Medical Leadership and Development events that they can avail of.

### 1.4 Appraisers

Currently, the Trust has 72 trained Medical Appraisers across all specialities within the Trust which also includes 16 SAS Appraisers who undertake appraisals of both SAS and Consultant colleagues. Each appraiser is expected to undertake 5 appraisals each per calendar year and protected time is allowed for them to undertake this role. Appraisees are also encouraged to seek an appraiser from outside their specialty.

### 1.5 Quality Assurance of Medical Appraisal

The Trust's Revalidation Team continue to oversee the quality of the medical appraisal process and review all appraisal documentation received into the Medical Director's Office to ensure there is sufficient evidence of appropriate supporting information, discussions and actions agreed. Where gaps are identified, the appraisal documentation is returned to both the appraiser and appraisee asking them to address the specified areas and resubmit the documentation for final approval. To date, the standard of medical appraisal within the Trust is extremely high and very few (less than 2%) of appraisal forms have been returned for resubmission.

### 1.6 Medical Appraisal and Revalidation Training

The total number of medical staff trained in the Trust's medical appraisal processes and the General Medical Council's (GMC) revalidation requirements is now 373 as at the end of 2017-2018. It is planned to hold one 'mop-up' session each year in recognition that almost all doctors should now be familiar with the requirements for both medical appraisal and revalidation. One further training session for new Medical Appraisers was held in April 2018 in recognition that some appraisers had left the Trust or relinquished the role and a further one will be held early 2019.

### 1.7 Medical Revalidation

To date (16th August 2018) all 322 doctors that have a GMC connection with the Trust have successfully revalidated during the first five year cycle which ended in March 2018. The second five year cycle is well under-way and there are approximately 65 doctors revalidating between 1 April 2018 to 31 March 2019, each of whom have been issued with all of their supporting information for revalidation and have been, or are in the process of being, registered for Patient and Colleague Feedback.

All doctors receive one to one support and advice during their revalidation process. This includes the provision of checklists and supporting documents required for revalidation, two face-to-face meetings, i.e. initial revalidation meeting and sign-off revalidation meeting to ensure the doctors meet both Trust and GMC standards for revalidation before a recommendation can be made by Medical Director to the GMC.



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

The Regulation and Quality Improvement Authority

# Review of Consultant Medical Appraisal

# Across HSC Trusts

Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

**Contents**



Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

# 1. SETTING THE SCENE

## 1.1 The Roles and Responsibilities of the Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland ) Order 2003 places a statutory duty of quality on Health and Social Care (HSC) organisations and requires RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

## 1.2 Context for the Review

Medical consultant appraisal was introduced on 1 April 2001 and it is a contractual requirement for all consultants and employers.

Appraisal for consultants is designed to be a professional process of constructive dialogue in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved.

The aims and objectives of the appraisal scheme are[1]

- to review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources;
- to optimise the use of skills and resources in seeking to achieve the delivery of service priorities;
- to consider the consultant's contribution to the quality and improvement of services and priorities delivered locally;
- to set out personal and professional development needs and agree plans for these to be met;
- to identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met;
- provide an opportunity for consultants to discuss and seek support for their participation in activities for the wider HPSS;
- utilise the annual appraisal process and associated documentation to meet the requirements for GMC revalidation.

[1] Circular HSS (TC8) 3/01



Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

The RQIA governance reviews in 06/07 assessed the achievement of HPSS Boards and Trusts against the first two themes of the HPSS Quality Standards[2];

- Corporate leadership and accountability of organisations;
- Safe and effective care.

Within the theme of Corporate Leadership and Accountability of Organisations a more detailed review was undertaken of appraisal of medical staff.

The 06/07 the RQIA overview report noted that there was significant variability in the uptake of consultant appraisal throughout the Trusts and at the time of the review there were a number of organisations that had not produced reports on consultant appraisal for Trust Boards. It was also noted that in some instances where reports had been produced, there was a lack of detail in several key areas.

The report recommended that all Trusts should ensure that annual consultant appraisals should be implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months). The report concluded that the area of consultant appraisal would be the subject of further scrutiny within the 07/08 review programme.

As a follow up to these recommendations the RQIA decided to carry out a desktop review, (using self assessment declaration) of consultant medical appraisal in 07/08. This report outlines the outcome of the desk-top review.

This review takes account of the arrangements in:

- Belfast HSC Trust
- Northern HSC Trust
- Southern HSC Trust
- South Eastern HSC Trust, and
- Western HSC Trust

## 1.3 Self Assessment

Self assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally. A self assessment proforma was developed (and submitted to trusts), based on the document "*Assuring the Quality of Medical Appraisal*" produced by the NHS Clinical Governance Support Team. The completed self analysis proforma together with supporting documentary evidence were returned to the RQIA for analysis. In meeting their legislative responsibility, the Chief Executive of each Trust signed a declaration confirming the accuracy of the self assessment return to RQIA.

[2] The Quality Standards for Health and Social Care. DHSSPS Mar 2006



Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

## 1.4 The Report

The report will be made available to the general public in print, at www.rqia.org.uk and in other formats on request.

In conducting this review, the RQIA acknowledges the significant organisational changes resulting from the merger of Trusts. It also acknowledges that the methodology of this review has led to limitations in the quality of information supplied by the Trust. The review methodology was not conducive to in-depth analysis nor did it allow examination of the implementation of policies and procedures. The views of appraisers and appraises were not sought. Therefore, the analysis of the effectiveness of the consultant appraisal system is limited.

The self assessment pro-forma was designed to undertake an initial assessment of the process of appraisal for consultant medical staff. It was not intended to explore all aspects of *"Assuring the Quality of Medical Appraisal".*

Following evaluation of this review the RQIA will work with the GMC, NIMDTA, PMETB, the Beeches Management Centre and Trust Medical Directors to develop an appropriate review methodology to assure the quality of medical appraisal in Northern Ireland.

## 2. FORMAT OF REPORT

The Clinical Governance Support Team in its report "*Assuring the Quality of Medical Appraisal*"[3] defined four high level indicators that would provide an indication that high quality appraisals were being undertaken.

1. **Organisational Ethos**
   There is unequivocal commitment from the highest levels of the host organisation to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

2. **Appraiser Selection, Skills and Training**
   The host organisation has a process for selection of appraisers and appraiser skills are continually reviewed and developed.

3. **Appraisal Discussion**
   The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan (PDP) prioritising the doctor's development needs for the following year.

[3] Assuring the Quality of Medical Appraisal. NHS Clinical Governance Support Team. July 2005.



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4. **Systems and Infrastructure**
   The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

Within each of the high level indicators there are supporting criteria some of which will be used to assess the quality of the Trusts' assessments of their appraisal systems and processes.



Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

## 3. ORGANISATIONAL ETHOS

The document *"Assuring the Quality of Medical Appraisal"* requires that under the heading of Organisational Ethos it should be demonstrated that there is **unequivocal commitment** from the highest levels of the host organisation to deliver a **quality assured system** of appraisal that is **fully integrated** with other systems of quality improvement.

### 3.1 Evidence of Organisational Commitment.

In order to demonstrate organisational ethos and commitment to appraisal the Trusts were asked to:

1) submit copies of current policies and procedures for annual appraisal / supervision for consultants and doctors in training, together with an organisational chart demonstrating the lines of accountability for the overall quality of medical appraisal;

2) provide the name of the doctor who has responsibility for leadership and the development of the consultant appraisal process;

3) describe the process for quality assuring the consultant appraisal process; how it is in integrated with other processes for Continuing Medical Education (CME) and clinical governance, and the Trust's commitment to time and resources to support appraisal system;

4) provide evidence of lay and public involvement in the consultant appraisal system;

5) indicate if an annual report on consultant appraisal is presented to the Trust Board.

**Summary of the analysis of the Trusts' returns**

**Policy -** all Trusts submitted a policy for appraisal of medical consultants setting out lines of accountability and giving an overall description of the appraisal process. Four of these were in draft form. Only the Northern Trust had an approved policy.

**Accountability -** all Trusts have similar lines of accountability for the appraisal system, with the Chief Executives having overall accountability to the Trust Board.

**Clinical Leadership -** the Medical Director on behalf of the Chief Executive, was identified as the person responsible for ensuring the integrity of the appraisal process and for monitoring the quality of appraisals undertaken. Lead clinicians in each department / directorate have responsibility for ensuring that arrangements are in place for all medical practitioners within their area of responsibility to have an annual appraisal. Individual consultants



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are responsible for participating properly in the appraisal process and for completing their agreed personal development plan.

**Quality Assurance -** all Trusts stated that they followed the "*Good Medical Practice"* guidelines and that they use the recommended documentation They also reported that training needs identified through PDPs are supported in terms of time and resources by the relevant clinical directorate.

**Lay and Public Involvement -** none was reported.

**Annual Report to the Trust Board -** only the Southern Trust had developed an Annual Report to be presented to the Trust Board in early 2008. The other Trusts had plans to report to their Boards at the end of the appraisal year.

**Number of Appraisals not undertaken -** Trusts were also asked to supply information on the percentage number of consultants who had not been appraised during the period 1 April 2006 - 31 March 2007. They were also asked to provide the reasons why appraisals had not taken place.

**Table 1. Percentage of consultants not appraised**

| Trust | % consultants not appraised | % locums not appraised |
|---|---|---|
| **Southern** | 13% (17/122) | 43% (7/16) |
| **South Eastern** | Estimated 40-50% | Information not supplied |
| **Western** | 47% | Information not supplied |
| **Northern** | 12% | 42% |
| **Belfast** | 28% | Information not supplied |

Trusts provided a range of reasons for non-appraisal which included:

- changes in medical personnel during RPA had adversely affected the completion of appraisals;
- loss of momentum as a result of delay in finalising GMC arrangements for revalidation;
- posts not filled permanently and turnover in locum staff;
- doctors appraised but not returning paperwork to Human Resources;
- Sick leave.

Table 1 highlights that consultant appraisals are not given a high priority in some Trusts.

In acknowledging the recent significant organisational changes as a result of the mergers of the 18 Trusts into five new Trusts this may not be unexpected. Nevertheless, consultant appraisal has been in place since 1 April 2001 and is a contractual requirement for all consultants and employers. A key feature of new registration arrangements introduced by the GMC is the concept of Approved Practice Settings which are organisations approved by the GMC as suitable for doctors new to full registration or returning to the medical register after prolonged absence from UK practice. One of the key criteria of an approved practice setting is a system of annual appraisal for individual



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doctors based on the principles of "Good Medical Practice" which is quality assured by an independent body or organisation.

Appraisal is also an important feature of revalidation which is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practice.

## 3.2 Evidence of Quality Assurance.

The following criteria were used to assess the quality assurance arrangements in place in respect of medical consultant appraisal;

- there is evidence of lay and public involvement in the appraisal system;
- quality assurance processes should include
    - an annual self assessment audit;
    - a three yearly objective assessment of the appraisal system by an appropriate independent group;
    - review of feedback questionnaires from appraisees;
    - appraisal summary forms and Personal Development Plans are reviewed annually and feedback given to the individual appraiser.

The final two points may also be used to review appraiser skills.

**Summary of analysis of Trusts' returns**

There was little evidence submitted that Trusts carry out an annual audit of medical appraisal systems. In the main, Trusts described an aspiration to meet the criteria outlined above. The Southern Trust was the only Trust to indicate that it carries out a yearly audit of 10 appraisal folders using the Quality Assurance Toolkit.

## 3.3 Evidence of Integration

The following Criteria were used to assess Trust submissions on evidence of the integration of appraisal systems into quality improvement and governance systems in the organisations.

- the appraisal system is integrated with other quality improvement systems in the host organisation e.g. continuing professional development and training, clinical governance, management of impaired clinical performance, workforce planning and human resources, risk management, service development, complaints;
- clear policies on the management of situations where a doctor's fitness to practice is impaired, including guidance on referral to National Clinical Assessment Service (NCAS) and General Medical Council (GMC);
- clear guidance on suspending appraisal when fitness to practice issues make it inappropriate to continue.



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**Summary of analysis of the Trusts' returns**

In the Southern Trust, the Annual Consultant Appraisal Report and Quality Improvement Plan are reviewed by the Trust's Senior Management Team, the Integrated Governance Committee and the Trust Board. Appraisal documentation reflects on relationships with patients and make reference to complaints and other governance processes.

In the Southern, South Eastern and Western Trusts there was an indication that the appraisal documentation also includes a statement of continuing Medical Education (CME) activities for discussion within appraisal. The Western Trust indicated that clinical governance issues are also covered by consideration of specific records of audits, clinical incidents, complaints and peer reviews.

The Northern Trust reported that a variety of governance processes are referred to appraisals. These include complaints, critical incident reporting and medico-legal claims. Doctors were expected to include this information in the appraisal documentation. The Trust also indicated that activity and outcome information was also used in the appraisal discussion where this is relevant and available.

All Trusts indicated that they had a policy in place to discuss problems arising from the appraisal process and for dealing with any underperformance issues identified during appraisal.

It is recommended in "Assuring the Quality of Medical Appraisal" that the appraisal system should be fully integrated with other quality improvement systems in the Trust. This should include in all cases, clinical governance information such as audit, adverse incidents, evidence of underperformance and complaints.

Trust self assessment returns and submitted appraisal policies do not demonstrate that the appraisal system has been sufficiently integrated with all other Trust quality improvement processes.

## 4. APPRAISER SELECTION, SKILLS AND TRAINING

All Trusts are required to have in place a process for selecting appraisers and ensuring that appraiser skills are continually reviewed and developed.

In order to demonstrate appraiser skills and training Trusts were asked to submit:

1) Procedures for selecting and recruiting medical staff appraisers (including job descriptions and person specification requirements);

2) A description of the training arrangements for medical staff appraisers;

3) A description of how medical appraisers were supported in their role;



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4) Their policy on the minimum and maximum number of appraisals completed by each appraiser annually;

5) A description of the arrangements for assessing individual doctor's appraisal skills.

The Trusts' submissions were subsequently assessed against the following criteria

- recruitment of appraisers uses a defined person specification and job description (which are included in a wider person specification/job description if appraisal is part of a wider role);
- the appraiser must participate in initial appraiser training;
- there are systems to ensure that initial training effectively addresses appraiser needs;

**Summary of analysis of the Trusts' returns**

The Southern Trust indicated that it uses a generic person specification as proposed for all NHS organisations and generally the speciality lead adopts the role of appraiser with support of the Clinical Director / Associate Medical Director. All Trusts indicated that the job description for an Associate Medical Director (or equivalent) and Clinical Director also includes responsibility for appraisals.

The Belfast and Northern Trusts indicated that they only used experienced clinicians with extensive local knowledge as appraisers to ensure continuity in its first year of the Trust's existence

The South Eastern Trust appointed Clinical Managers through seeking expressions of interest from consultants working internally within the speciality or directorate. They did not have a specific policy for the recruitment of appraisers. In the Western Trust the generic NHS person specification was included in the policy document. The Medical Director took responsibility for recruiting appraisers through a process of volunteering or nomination by the clinical director.

All Trusts indicated that they used the formal training programme run by the Beeches Management Centre for the initial training of appraisers. Only the Belfast Trust indicated that the training was verified by senior medical managers.

None of the Trusts reported that they had adopted a formal process for selecting appraisers. This is something they may wish to consider as the Trusts mature following their establishment.



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## 4.1 Evidence of Review and Development of Skills

The following criteria were used to assess evidence of the review and development of appraisal skills.

- there are systems in place for appraisal and performance management of appraisers;
- there are systems in place to ensure that appraisers participate in on-going training and development and that training is effectively addressing appraiser needs;
- there is guidance regarding the minimum and maximum number of appraisals per appraiser per year;
- there is a process for periodically assessing appraiser skills e.g. anonymous review of appraisal summary forms and PDP.

**Summary of analysis of the Trusts' returns**

The Southern Trust indicated that it undertakes audit to assess and summarise recurrent themes identified in the process for each appraiser. The Northern Trust stated that it had carried out an appraisee satisfaction survey in the past but had no current specific method for reviewing appraiser skills.

The remaining Trusts did not indicate that they had or were reviewing the skills of appraisers.

All Trusts indicated that appraisers receive on-going training but it is unclear from their submissions to whether this is a regular process, although the Northern Trust indicated that training is carried out on a three-yearly basis.

All Trusts stated that they have guidance in place on the maximum and minimum number of appraisals per appraiser per year.

Analysis of the information shows that there appears to be no formal process for review and performance management of appraisers and little evaluation of the effectiveness of the appraisal discussion. This is vital in informing issues to be covered in ongoing training and development of appraisers.

## 5. THE APPRAISAL DISCUSSION

It is a requirement that the appraisal discussion is challenging and effective. It should be informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a PDP prioritising the doctor's development needs for the coming year.

In relation to the appraisal discussion, the self assessment pro-forma asked Trusts to:

1) Describe the process for reviewing Appraisal Summary Forms and PDPs;



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2) Provide results of the most recent review of the appraisal forms in use, and any developmental action taken;

3) Describe the procedure followed should problems arise within the appraisal process;

4) Describe the process for dealing with serious underperformance issues identified during the appraisal discussion;

5) Describe arrangements in place to ensure that the needs of personal development plans are supported by the relevant clinical directorate;

6) Provide numbers of practitioners referred to NCAS or GMC as a result of an appraisal interview.

## 5.1 Evidence that the Appraisal Discussion is Challenging and Effective.

The following criteria were used to analyse the Trusts' self-assessment returns relating to the nature of the Appraisal discussion:

- the previous year's PDP is reviewed;
- a new PDP is produced;
- colleague and patient feedback is discussed;
- there is evidence of a change of appraiser after a maximum of three appraisals;
- performance management and development systems address challenge within the appraisal discussion.

**Summary of analysis of the Trusts' returns**

It would appear from the Trusts' submissions that there is evidence that individual PDPs developed at the time of appraisal are used to inform the appraisal discussion and in some instances are used to assess the appropriateness of continuing medical education of individual clinicians. Although there was evidence in Belfast, Western and South Eastern Trusts that senior medical managers review and sign off the PDPs, this needs to be formalised and integrated into the wider governance processes of the individual organisations.

It would appear that PDPs are not reviewed and feedback given to individual appraisers on content and quality.

There is no evidence within the Trusts' submissions that there is a change of appraiser after a maximum of three appraisals. It was indicated that this was difficult to achieve in the smaller sub specialities and in some small directorates.



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## 5.2 Evidence of Valid and Verifiable Supporting Evidence

The following criteria were used to analyse the Trusts' returns relating to valid and verifiable supporting evidence of the clinician's practice at the time of appraisal.

- there is a core portfolio of supporting evidence which reflects the breadth of the doctor's practice and conforms to national, GMC and Royal College standards and guidance;
- the supporting evidence includes feedback from patients and colleagues;
- there is guidance and training for appraisers for situations when evidence is insufficient.

**Summary of analysis of the Trusts' returns**

Analysis of the Trusts' returns was inconclusive in providing assurance that evidence from patients and colleagues forms part of the appraisal discussion in all Trusts. However, the Western Trust indicated that patients and clients are involved in 360 degree feedback. The Belfast and Northern Trusts are piloting a programme of 360 degree feedback.

It is unclear if there is any guidance on what would be regarded as sufficient and appropriate evidence for an appraisal and also unclear if there is any guidance for appraisers for these situations.

# 6. SYSTEMS AND INFRASTRUTURE SUPPORTING APPRAISAL

## 6.1 Evidence of Effective Supporting Systems and infrastructure

It is a requirement that the supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

The following criteria were used to analyse the Trusts' returns in respect of support systems and infrastructure;

- there is dedicated administrative support for the appraisal system;
- there is clearly identified managerial responsibility for the appraisal;
- adequate notice is given to prepare for the appraisal discussion;
- there is protected time for the appraisal discussion;
- there is guidance on potential conflicts of interest between appraiser and appraisee;
- there is guidance on the environment within which the appraisal discussion takes place;
- there is a system for handling complaints about appraisal.



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**Summary of analysis of the Trusts' returns.**

Each Trust supplied an organisational chart that demonstrated the lines of managerial accountability and responsibility for the overall quality of medical appraisal. They also indicate that they provide guidance on appraisal planning and timescales for agreeing date of appraisal, sharing of documentation and setting of the agenda for the appraisal discussion.

Trusts also indicated that they provide clear guidance on potential conflicts of interest prior to the appraisal discussion and on any issues or difficulties arising from the appraisal discussion and clear guidance on an environment for the appraisal discussion that guarantees privacy and confidentiality.

It was notable that the Southern Trust reported that they had clearly identified four hours of Special Programmed Activity (SPA) time for appraisers. This was allocated for preparation and conduct of each appraisal. Appraisees were allocated eight hours of SPA time annually for appraisal.

Although guidance has been provided on conflicts of interest and issues arising at the time of the appraisal discussion, it is unclear from the self assessment returns if there was a formal appeals mechanism which appraisees can access after appraisal has taken place.

## 7. CONCLUSIONS

Annual appraisal for all doctors was a recommendation in the Chief Medical Officer's report "*Supporting Doctors, Protecting Patients*". Consultant medical appraisal was introduced in April 2001 and is now a contractual requirement for all doctors working in the NHS. Appraisal should be an integral part of an organisation's governance systems and processes. Satisfactory delivery of appraisal should be a factor in delivering the quality and safety agenda.

A DHSSPS review of medical appraisal in Northern Ireland was published in January 2006 and it made several recommendations in relation to Consultant appraisal:

1) Trusts should have written policies for appraisal covering all medical staff;

2) Job descriptions with specific competences should be created for appraisers and should be integral to all job descriptions for Medical Directors, Clinical directors and Heads of Department;

3) Training requirements, including update training should be specified and appraisers not meeting those requirements should be removed from the list of appraisers;

4) Trusts should develop a minimum data set to support appraisal which will help to ensure consistency easing time pressures;



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5) Every Trust should produce an annual report for the Trust Board covering all doctors holding contracts of employment at the Trust and reporting uptake. The report should include an evaluation of the appraisal process, including those benefits arising for patients/carers and for doctors and should assess the extent to which objectives in Personal Development Plans align to the corporate agenda.

While some of these recommendations have been met / partially met a number still require further work to assure compliance.

The Trust returns indicate that in certain areas there is a significant shortfall in the number of consultants and possibly locums that have been appraised, this is concerning given the fact that the requirements for appraisal have been in place since April 2001.

There is an indication from Trusts that there are organisational structures in place demonstrating lines of managerial responsibility and accountability. However, there is no formal system for review and performance management of appraisers and there is little evidence of the evaluation of training and of the outcomes of the appraisal process.

This is the second occasion that RQIA have sought assurance on the structure and functions in HSC organisations in respect of consultant appraisal. Including the Departmental review published in 2006 it is the third time that the consultant appraisal system has been reviewed and recommendations made and yet this review indicates that there is still significant variability in the provision of consultant medical appraisal and also significant variability in appraisal systems across Trusts.

The RQIA acknowledges the difficulties associated with the merger of the Trusts and also has acknowledges that the review methodology has led to limitations in relation to the quality of information supplied by the Trusts. The desktop methodology does not permit in depth analysis of the appraisal system nor scrutiny of the effectiveness of the implementation of policies and procedures. It also does not include the views of appraisers and appraises. The effect of this is to limit the analysis of the effectiveness of the consultant appraisal system.

The self assessment proforma did not explore in sufficient detail all aspects of the document *"Assuring the Quality of Medical Appraisal"* and specifically did not investigate in sufficient depth the status of locum appraisal and appraisal for doctors in training.

In the future RQIA will:

1) consider a more robust methodology for further scrutiny of consultant medical appraisal including a refined self assessment document and visits to trusts by an RQIA review team;



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2) work with other stakeholders such as the GMC and perhaps the Beeches Management Centre in developing a more robust assurance tool;
3) work with other agencies such as NIMDTA and PMETB to assure the quality of appraisal of all categories of doctors;
4) work with trust Medical Directors to develop a system for assurance of medical appraisal consisting of an annual electronic return with assurance visits on a periodic basis.

## 8. SUMMARY OF RECOMMENDATIONS

While there is an opportunity to make detailed recommendations across a range of key criteria in the delivery of effective consultant and locum medical appraisal systems this would be more appropriate following a more robust review.

Trusts should be aware that Consultant medical appraisal has been in place since April 2001 and is a contractual requirement for all doctors working in the NHS. Satisfactory delivery of appraisal is a significant part of the quality and safety agenda.

RQIA recommends that all Trusts should as a matter of urgency comply in full where possible with the four high level indicators outlined in *"Assuring the Quality of Medical Appraisal"* and with the sub criteria outlined within this report. Trusts should also note the recommendations contained in *"Assuring the Quality of Training for Medical Appraisers".*

Trusts should indicate how they propose to comply with the above criteria and how they will ensure that all medical personnel are appraised, in an action plan to RQIA no later than the 30th November 2008.



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The Regulation and Quality Improvement Authority

# Review of Governance Arrangements in HSC Organisations that Support Professional Regulation

January 2017

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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**The Regulation and Quality Improvement Authority (RQIA)** is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. The majority of our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting on four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Are services well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

The review was undertaken by Dr David Stewart (Reviews and Medical Director, RQIA), Dr Gareth Lewis (Clinical Leadership Fellow, RQIA), and Ronan Strain (Project Manager, RQIA).

RQIA thanks all those people who facilitated this review through participating in discussions, interviews, attending focus groups or providing relevant information. We would particularly like to thank the following HSC organisations and Professional Regulatory Bodies for providing information to underpin the review process:

- Health and Social Care Trusts (HSC Trusts)
- Health and Social Care Board (HSC Board)
- Public Health Agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- General Medical Council (GMC)
- Northern Ireland Social Care Council (NISCC)
- Northern Ireland Medical and Dental Training Agency (NIMDTA)
- Nursing and Midwifery Council (NMC)
- General Dental Council (GDC)
- Pharmaceutical Society Northern Ireland (The Society)

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

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## Executive Summary

As part of its 2015-18 review programme, RQIA conducted a review of Governance Arrangements in HSC Organisations that Support Professional Regulation. The review examined the clinical and social care governance arrangements to consider if they were in keeping with the standards and guidelines set by HSC Organisations and Professional Regulatory Bodies, in order to provide assurances to the Northern Ireland public that all health professionals are registered and fit to practise.

Individual professionals are personally accountable for their professional practice and must participate in the activities required to maintain their registration with their professional regulator. HSC Organisations need to ensure that the professionals they employ are supported, monitored and facilitated to meet the requirements of their professional regulators.

RQIA found that all eight HSC organisations involved in this review had robust governance arrangements in place, to ensure essential requirements for professional registration and regulation are adhered to.

Each organisation had effective generic processes in place in relation to:

- Annual checks to ensure that professionals adhere to their registration requirements
- Handling concerns and complaints about individual performance
- Annual appraisal processes and supervision

For individual professions RQIA found that:

- Arrangements for the revalidation of medical staff were now embedded
- Systems were in place to take forward nursing revalidation
- There were arrangements and systems to support the registration of the social care workforce, to include social care workers
- Pharmacists, dentists and bio-medical scientists function in well-regulated environments

RQIA was also provided with examples which demonstrated that HSC organisations understand the importance of professional registration and regulation of their workforce. Registration and regulation is now regarded as a core component of provision across all services, and is recognised to be valuable in the context of service change, increasing demands and expectations, and growing complexity of service users.



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# Chapter 1: Introduction

## 1.1 Introduction

The Department of Health in England white paper: *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, which was published in February 2007[2], sets out a programme of reform for the United Kingdom's system for regulation of health professionals.

In Northern Ireland, health and social care (HSC) organisations are responsible and accountable for assuring the safety, quality and availability of the services they commission and provide. Integral to this is effective leadership and clear lines of professional and organisational accountability, achieved through a robust governance framework.

Professional regulation systems, such as registration and revalidation, are a vital component of effective governance and management arrangements. Although these systems are the responsibility of the professional regulatory body, they should be complemented and mutually supported by the employing HSC organisation to assure the Northern Ireland public that all health professionals are registered and fit to practise.

To underpin these systems of professional regulation and to ensure the provision of high quality services, each HSC organisation needs robust systems of clinical governance and appraisal.

Enhancing and strengthening the process of appraisal requires clinical governance and quality improvement systems to function effectively in support. It is important for HSC organisations that appraisal operates effectively as an intrinsic part of their clinical governance and quality improvement systems.

Information requirements and arrangements for information sharing between these systems should be clear. Integration of these systems should help staff produce supporting information for their portfolio, where appropriate, but also enable performance concerns to be dealt with effectively, in a timely manner and not delayed until the appraisal discussion.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf



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## 1.2 Context of the Review

During the RQIA consultation to develop a prioritised programme of thematic reviews for the period 2015-18, RQIA was requested to review the governance arrangements in HSC organisations that support professional regulation.

There are increasing demands placed on health and social care services in Northern Ireland due to an ageing population, high patient expectations, increasing prevalence of chronic conditions, advances in technology and therapeutics, and changes in the way services are delivered.

It is clear that professional staff in Northern Ireland have many challenges ahead. It is important that the people of Northern Ireland are assured that staff are fit to practise and HSC organisations have robust governance processes in place to continue to be safe and effective.

In November 2009, the General Medical Council (GMC) commenced the work on arrangements through which every doctor wishing to remain in active practice in the United Kingdom is required to hold a licence to practise, by undergoing a process of revalidation.

Revalidation largely draws on existing clinical governance systems and relies on each doctor collecting a portfolio of evidence over a five year cycle to comply with standards set out by the GMC. In June 2010, legislation enacted by the Northern Ireland Assembly required each body designated by the legislation to appoint a Responsible Officer (RO). The RO is responsible for ensuring that effective clinical governance arrangements are in place and for making a revalidation recommendation to the GMC, concerning doctors linked to their organisation.

Between 2008 and 2011, RQIA carried out the following reviews that concluded that these processes were well established with effective leadership.

- Review of Appraisal Arrangements Provided by NIMDTA for Primary Care
- Review of Readiness for Medical Revalidation in the HSC Trusts
- Review of Readiness for Revalidation in Primary Care in Northern Ireland

Clinical governance and quality improvement systems should be reviewed regularly to ensure they are fit for the purpose of supporting professional regulation.

As part of its 2015-18 review programme, RQIA has carried out this review, to gain assurance as to the effectiveness of the existing governance arrangements in HSC Organisations that Support Professional Regulation.



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The RQIA review focused on the following professions employed by commissioners (HSC Board & PHA) and providers (HSC Trusts):

- Doctors
- Nurses & Midwives
- Social Workers & Social Care Workers
- Pharmacists & Pharmacy Technicians
- Community Dentists & Dental Care Professionals

The review also focused on the Northern Ireland Blood Transfusion Service (NIBTS). The NIBTS is an independent, Special Agency of the Department of Health (DoH). It is responsible for the collection, testing and distribution of over 64,000 blood donations each year. The Service operates three mobile units at around 250 locations throughout the province. The NIBTS employs a number of medical and nursing professionals, as well as a large cohort of biomedical scientists and laboratory assistants. Biomedical scientists are required to be registered and regulated to ensure they are fit to practise. The review team acknowledged that the NIBTS operates within a highly regulated environment; however, the review team felt it was important to include biomedical scientists and laboratory assistants employed by NIBTS in this review.

The review did not focus on the following health professionals as these professions have been reviewed by RQIA throughout 2015:

- Allied Health Professions (AHPs)
- Northern Ireland Ambulance Service (NIAS)
- General Practitioners (GPs)



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## 1.3 Terms of Reference

The Terms of Reference of the Review:

1. Review the effectiveness of the governance arrangements in place within HSC organisations which underpin systems of professional regulation for the following professions:

    - Medicine
    - Nursing and Midwifery
    - Social Work (to include Social Care Workers)
    - Pharmacy (to include Pharmacy Technicians)
    - Community Dentistry (to include Dental Care Professionals)
    - Biomedical Science (NIBTS Only)

2. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements if required.

## 1.4 Methodology

The review methodology was designed to gather information about current governance arrangements in HSC organisations (including those that Support Professional Regulation).

The methodology was as follows:

- Literature search/review to determine relevant areas in relation to clinical governance and professional regulation.

- Discussions with Professional Regulatory Bodies (GMC, NISCC, NMC, GDC, and the Pharmaceutical Society of Northern Ireland).

- Self-assessment questionnaire completed and returned by HSC Trusts, HSC Board, PHA, & the Northern Ireland Blood Transfusion Service.

- Formal Meetings with senior representatives from each HSC organisation's professional group.

- Focus groups with frontline staff.

- Regional Summit Event involving all relevant stakeholders, to present findings and draft recommendations.

- Publication of an overview report of the findings of the review.



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# Chapter 2: Findings

Findings from the review are presented in two sections:

1. Generic Governance Arrangements that Support Professional Regulation
2. Profession Specific Governance Arrangements that Support Professional Regulation

## 2.1 Generic Governance Arrangements that Support Professional Regulation

### 2.1.1 Registration

The review found that all HSC organisations have robust systems and processes in place, to ensure that employed professional staff adhere to their registration requirements on an annual basis. HSC organisations follow a Registration and Verification Policy which assures registration is addressed. The review also found that HSC organisations have policies for the employment of Locum and Agency Staff. For example, recruitment teams within each organisation carry out checks of professional registration and qualifications that are listed as essential criteria in job specifications. A copy of the applicant's qualification certificates and a print out from the professional body's website is also required and will be retained on their personnel file.

All HSC organisations maintain an alert letter database. This contains names of individuals who are under investigation, or who have been suspended or dismissed by an HSC employer, or who are considered by an employer to be a potential danger to the safety of patients, other staff or themselves. Recruitment teams check the alert letter database prior to forwarding a final offer to ensure that the applicant is not the subject of an alert.

All successful applicants are required to provide evidence of valid registration as part of normal pre-employment checks. Professional registration expiry dates are also recorded on the new HRPTS portal within HSC organisations, which are checked on a regular basis to ensure a registration has not lapsed.

HSC organisations are assisted by staff in the BSO Recruitment Shared Service Centre to subsequently check registration via the regulatory body's website checker, in order to confirm the applicant's registration remains valid on the date of the check.

Prior to any interview, the interview panel will review the application form to confirm live registration is in place and to discover whether the applicant has or has had any referrals to/investigations by the regulatory body. If it is noted that the applicant has declared any such issues, then the interview panel will explore this further with the applicant, at the end of the interview, having completed the normal assessment process. The panel will then decide if the



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applicant is suitable for the post or not and will discuss how any issues relating to their practice can be accommodated in their role.

Following recruitment, staff will have their registration checked internally on a regular basis and reviewed at annual appraisal or supervision.

HSC organisations have mechanisms in place to check the status of staff by visiting online registers. For example, HSC Trusts are able to retrieve details for a number of staff at any one time, and be able to identify those medical staff who are:

1. registered with a licence to practise
2. registered without a licence to practise

In addition, HSC organisations have developed mechanisms to check staff registrations on a regular basis. Individual email reminders are also sent out to staff whose registration is due for renewal.

## 2.1.2 Handling Concerns and Complaints about an Individual's Performance

The review found that HSC organisations have effective internal and external processes and arrangements in place for handling concerns and complaints about individual performance. Where concerns are identified by a patient, service user or carer about the performance, conduct or competence of an individual staff member, the HSC Complaints Procedure[3] is used. Where concerns are identified regarding underperforming staff by other staff members, the organisation seeks to engage with the individual staff member to explore their presenting and underlying difficulties.

The review found that organisations follow the guidance of Maintaining High Professional Standards in the Modern NHS (MHPS)[4] framework in relation to specific concerns which are subsequently investigated following a defined procedure. Depending on the nature of the concern and the findings the organisation may then follow either disciplinary or capability procedures.

The capability procedure is used where there is evidence of a genuine lack of ability rather than a deliberate failure on the part of the employee to perform to standards of which he/she is capable. The aim of this procedure is to improve their performance through on-going monitoring and support.

The disciplinary procedure is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-complaints-standard-and-guidelines-for-resolution-and-learning-updated-february-2015.pdf
[4] http://www.ajustnhs.com/wp-content/uploads/2012/05/Dept-of-Health-Discipl-Appeal-2005.pdf



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Organisations may also seek to engage external organisations such as the National Clinical Assessment Service (NCAS)[5] which contributes to patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists.

The review found that HSC organisations have various other policies and procedures in place that complement their procedures for managing concerns/complaints such as:

- Policy & Procedure for reporting & management of incidents
- Policy for completing IR1 incident form (near miss & incident record form)
- Whistleblowing Policy
- Working Well Together Policy
- Management and Handling of Complaints
- Disciplinary and Competence policies and procedures
- Procedures for Initiating and responding to referrals to Professional Regulatory Bodies and Independent Safeguarding Authority
- Requesting DoH to issue an ALERT

Senior staff within trusts, in conjunction with their HR Employee and Engagement team will investigate concerns about an individual's conduct and the potential impact on their fitness to practise. If this is found to be impaired and the individual is dismissed from employment, the case is forwarded to senior management to consider referral to the appropriate regulatory body.

The review found that many concerns or complaints are dealt with effectively at the time they are discovered and not delayed until an appraisal discussion. A collaborative decision is taken whether to refer individual workers to their regulatory body, following disciplinary or capability procedures. Regulatory bodies are automatically informed when a worker is suspended from work pending disciplinary/investigation action.

There are a variety of potential outcomes depending on the severity of the level of under-performance; for example, retraining, supervision, disciplinary action, change of duties, referral to occupational health, or referral to the relevant regulatory body.

The Whistleblowing Policy also provides guidance for staff on how to report concerns of wrongdoing, malpractice or inadequacies in the provision of services, and should provide protection for those staff that raise concerns.

[5] http://www.ncas.nhs.uk/



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### 2.1.3 Sharing Internal and External Complaints and Incidents

The review found that HSC organisations have systems and processes for the collation, investigation and management of comments, complaints, incidents, serious adverse incidents (SAIs) and litigation.

Any internal or external complaints or incidents will be reported and managed initially via the organisation's incident reporting and investigation process and the DATIX system records and supports the management of these processes. Learning reports and outputs of DATIX are used to support a variety of governance structures and learning activities. Clinical Leads and senior staff investigate incidents and identify actions and learning.

The review found that HSC Trusts have a Safer Recruitment and Employment Alert Notice System Procedure that sets out the arrangements within their trust for the processing and issuing of Alert Notices.

Where a registrant receives sanctions, or is suspended or erased from the professional register by a regulatory body following a complaint or incident, senior management contact the DoH requesting the issuing of an Alert Letter to external bodies. Where circumstances dictate, a referral may also be made to the Independent Safeguarding Authority.

External complaints from service users/carers regarding staff are dealt with under the Regional Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (DHSSPS 2009)[6]. Learning and/or concerns from complaints can be escalated to Assistant Directors and Executive Directors if required. Senior management teams work in collaboration with other multidisciplinary teams to monitor complaints/incidents regarding trends, risks and potential escalation.

Learning is also shared through appropriate governance arrangements such as, Lessons Learnt Committees, Newsletters and Lessons of the Month initiatives. Serious Adverse Incidents are also reported to external organisations; for example, HSC Trusts report to the HSC Board/PHA in line with an agreed SAI process.

[6] https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20%20Standard%20and%20Guidelines%20for%20Resolotion%20and%20Learning%20-%20Updated%20February%202015.pdf



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## 2.2 Profession Specific Governance Arrangements that Support Professional Regulation

### 2.2.1 Medical Profession

#### Generic Governance Arrangements

In the organisations that were the focus of this review, the review team acknowledged that medical professionals work in well-established regulated environments. However, it can be a challenge for these organisations to ensure all medical professionals have a full understanding of the governance arrangements, systems and processes within the organisation in which they work. The review also found concerns in relation to the transfer of timely and accurate information when medical staff move between HSC organisations, especially in relation to an individual's professional performance, complaints, and incidents.

#### Appraisal, CPD and Revalidation

The review found that all HSC organisations have appraisal systems and processes in place to annually appraise their doctors, and check they are up to date and fit to practise. Annual appraisal is a contractual requirement, and is seen by an increasing majority of medical staff as an essential part of their profession, and an opportunity to "showcase" their work. Evidence from the review highlighted a shift away from viewing appraisal and revalidation as a "tick-box" exercise, towards a process in which a quality portfolio was used to provide evidence of good clinical work and professional development.

HSC organisations have developed a range of policies covering appraisal and revalidation, for example, 'Medical Appraisal & Revalidation Policy' which is designed to strengthen the link between appraisal and revalidation. Some HSC organisations also maintain a webpage dedicated to Medical Appraisal and Revalidation which is the primary source of all relevant publications (trust and regional) and includes a range of supporting documentation and templates.

Registered doctors are required to follow CPD recommendations of the various Royal Colleges, for example, completion of 50 hours CPD per year, 25 hours of which must be externally accredited.

RQIA is aware that doctors typically have time set aside for non-clinical activity, however, during focus groups, some doctors highlighted difficulties with meeting their CPD requirements, within their allocated Supporting Professional Activity allowance and would welcome more protected CPD time within work.

Appraisal rates for 2013-14 and 2014-15 in HSC organisations ranged from 71% to 100% for all eligible medical staff.



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| Recommendation 1 | Priority 2 |
|---|---|
| RQIA recommends that HSC Trusts report profession-specific appraisal rates for all eligible professional staff in their Annual Quality Report. | |

Revalidation was introduced in December 2012 and required all licensed doctors to demonstrate on a regular basis that they are up to date, fit to practise in their chosen field, and able to provide a good level of care. Licensed doctors have to revalidate every five years and this is supported by having annual appraisals based on the core guidance for doctors, *Good medical practice*[7]. Annual appraisal, in addition to being a contractual requirement, is a pre-requisite to securing a positive recommendation for revalidation. The review found that some HSC organisations have established dedicated revalidation support teams or departments to assure that doctors continue to meet the professional standards set by the GMC and the relevant Royal Colleges. Senior administrative/managerial support was felt by some HSC organisations to be essential in supporting delivery of medical revalidation locally.

To strengthen the appraisal process, HSC organisations have identified a number of Medical Appraisers who are required to undergo specific training. In addition, some HSC organisations have produced the following in an effort to deliver consistency:

- Appraiser and appraisee handbooks
- Good Practice Guidance for Completion of Clinical Appraisal Form 3 and PDP's
- A standardised 'Template for Assessing the Quality of Evidence for Appraisal and Revalidation'

These arrangements provide assurance for the public and patients that medical staff are supported in maintaining high professional standards in the workplace.

The review did find variances across HSC organisations in relation to electronic and paper based appraisal and revalidation portfolios. The majority of organisations would welcome a centralised electronic version, however, there does need to be a balance with face-to-face contact and the option of using paper and pen for some appraisers.

The review found that appraisal is an individual organisational activity, however, systems and processes are not standardised across organisations.

The review found that the Western HSC Trust has been working on developing revalidation systems, the utility of which could be explored by other HSC trusts/relevant HSC bodies.

[7] http://www.gmc.uk.org/The_Good_medical_practice_framework_for_appraisal_and_revalidation___DC5707.pdf_56235089.pdf



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## Support, Education & Learning

The review found that HSC organisations have varied systems and processes in place for educational governance and leadership to manage and deliver education, training, and CPD opportunities for their medical staff. Some have developed a number of initiatives and good practice which include:

- A Learning and Development Agreement for the provision of postgraduate medical training and education with NIMDTA. This agreement sets out the systems of education governance and leadership to manage and deliver education training and CPD opportunities for medical staff.
- Dedicated websites for doctors for all information pertaining to appraisal and revalidation, medical training and medical induction.
- Specific departmental induction programmes for each division, with a number of core mandatory training modules that doctors must complete as a condition of commencing employment.
- Induction meetings with the Medical Director for each new permanent medical member of staff. At this meeting initiatives such as Medical Leadership and Development programmes and Mentoring Schemes are highlighted.
- HSC Trusts operate an Appraisal Induction Scheme for all new starts, which encourages early development of a Personal Development Plan (PDP).
- Morbidity and Mortality (M&M) review meetings are also a core educational component for doctors. Work is ongoing in some trusts to support a regular M&M meeting for all doctors.
- Review of Complaints/Incidents/ SAIs. SAIs are screened by Associate Medical Directors and regional learning is shared in the form of 'learning letters' that are circulated by the HSC Board and PHA to all medical staff.
- Regular lunchtime Staff Grade and Associate Specialist (SAS) doctors' Link-Up sessions which are held across the trusts.
- In-house Medical Leadership and Development events.
- A standard process for applying for study leave and funding for doctors in training.
- Planned audit and review of all doctors' PDPs as part of an appraisal round.
- Departmental learning events for doctor's e.g. weekly journal clubs etc.

HSC organisations welcome the presence of a local GMC office in Northern Ireland and they have also developed close links with the GMC Employment Liaison Adviser. Organisations regularly engage with the GMC for guidance, support and to discuss cases of concern, fitness to practise thresholds, registration queries and to seek advice in individual circumstances.



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The role of the GMC Liaison Adviser in Northern Ireland is to engage with medical staff in trusts, doctors in training and those who are new to United Kingdom practice. They provide practical support and targeted discussion around GMC standards, guidance and reviews.

The review team heard the experience of one doctor who was returning to work after raising a family. They faced a potentially complex journey to becoming reinstated on the medical register, being employed by a trust, and having to provide supporting documentation for a first appraisal. This doctor described a very positive experience from the initial support provided, through to an identity check with the GMC in Manchester and providing evidence of her CPD via a GMC smartphone application. The review team was impressed with the smoothness of the transitions between professional and regulatory governance arrangements and structures. The doctor was assured by these processes that she was both fit to practise and had clear evidence to support this.



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## 2.2.2 Nursing and Midwifery Profession

### Readiness for Revalidation

Revalidation for all nurses and midwives in the United Kingdom began to be compulsory from April 2016. In addition to demonstrating nurses' and midwives' ability to practise safely and effectively it is designed to encourage reflection upon, and living out the standards contained within the NMC Code[8].

This new process replaces the old post-registration education and practice (Prep) requirements. Nurses and midwives will have to revalidate every three years to renew their registration.

The review team was provided with evidence that relevant HSC organisations have put significant arrangements in place to become ready for NMC revalidation. These included:

- Base line assessments to identify current registrants e.g. Midwives, Nurses, Bank Only Nurses, and Bank Only Midwives
- Supporting and engaging nurses and midwives to assist understanding and application of the NMC's revised Code
- Scoping individual and managerial readiness to ensure timely revalidation
- Information and Awareness sessions delivered by NIPEC and NMC
- Development and implementation of guidance on collating feedback from patients and colleagues
- Supporting confirmers and third-party appraisers in their roles and ensuring they understand their responsibilities
- Supporting managers to put in place systems to facilitate discussions and confirmer meetings ensuring they understand their responsibilities
- Developing methods of assurance on consistency in confirmers'/ third-party appraisers' judgements
- Engaging with training providers, e.g. the Clinical Education Centre (CEC), to support revalidation learning and compliance activities
- Revalidation Implementation Groups will support implementation of the new arrangements across the directorates
- Ongoing development of a bespoke database to monitor revalidation status across the organisation (HRPTS functionality to capture high level nursing revalidation information was under development at the time of fieldwork)
- Monthly reporting to identify those whose annual fee and revalidation is due
- Communication strategies to alert registrants to the additional requirements and timescale for revalidation
- A Regional Revalidation Programme Board, Co-Chaired by the CNO and Director of Human Resources (DoH)

[8] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf



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The review found that nursing and midwifery teams are becoming increasingly multidisciplinary, with collaborative working across specialities. For example, nurses working in multidisciplinary teams where the management is not nursing or midwifery led. The NMC revalidation process is registrant led and individual registrants are responsible for their own revalidation. However, significant work has been undertaken by HSC Trusts in order to support registrants to meet revalidation requirements. With regard to nurses working in primary care, the review team would also like to acknowledge the work of NIPEC and the PHA who undertook a programme of intensive work to communicate with and support practice nurses attached to GP practices with revalidation requirements.

During preparations for the introduction of NMC revalidation, significant steps were taken to ensure organisations representing all groups were informed and reminded of their responsibilities regarding the cascade of information.

### Appraisal, Knowledge and Skills Framework (KSF) and Supervision

The review found that all HSC organisations have processes and systems in place for annual appraisal of all nursing and midwifery staff. Arrangements under Agenda for Change and the HSC KSF/Appraisal Policy require that all NMC registrants have a yearly appraisal meeting with their line manager. The standardised documentation which supports this process has been adapted to incorporate the NMC Code.

In 2007, the Chief Nursing Officer (CNO) for Northern Ireland published 'Standards for Supervision in Nursing' which requires nurse registrants to undertake a clinical supervision meeting with their line manager twice per year[9]. At the time of this review midwives were subject to the separate process of Statutory Supervision of Midwives through the Local Supervising Authority (LSA) in Northern Ireland (the Public Health Agency). The standards for supervision of midwives are set and monitored through the 'Midwives rules and standards' (NMC 2012). The LSA reports annually on supervision, and is audited by the NMC. Statutory supervision of midwives by the NMC is currently under review by government and will soon be subject to legislative change'.

Every three years, nurses and midwives need to revalidate in order to renew their registration. From April 2016, revalidation includes requirements in the previous three years for at least 450 practice hours and 35 hours of CPD, at least 20 of which must include participatory learning.

Feedback from frontline staff highlighted that supervision and annual appraisal are seen as a core component of their work, and contribute to high quality, effective and efficient revalidation every three years. Annual appraisal is a contractual requirement, while supervision is a standard set by the profession.

[9] http://www.nipec.hscni.net/work-and-projects/previousworkandprojects/supervision-standards-for-nursing-project/supervisionstandardsnursing-docs/



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## Support, Education & Learning

HSC organisations provide Nursing and Midwifery induction programmes three times per year for all new nursing and midwifery staff. As part of pre and post registration, all new nursing and midwifery staff undertake induction education programmes in medication management to meet NMC requirements.

During and following completion of their preceptorship period, nursing staff must complete an Intravenous Drug Administration course which is supported by a competency framework tool. All registered nursing staff update their training on administration of medicines on a three-yearly basis, as a mandatory requirement set by HSC Trusts.

The review also found that all HSC organisations have systems of educational governance and leadership to manage and deliver education, training, and KSF/CPD opportunities for registered nursing and midwifery staff. Education, training and CPD opportunities are managed in a variety of ways:

1. CPD opportunities are identified through the process of annual appraisal.
2. In house mandatory training is managed and delivered by the organisation using face to face and e-Learning methodologies.
3. Dedicated training teams manage targeted training e.g. Mentorship, Infection Control.
4. A Service Level agreement with the Clinical Education Centre (CEC) permits access to a variety of training courses; HSC organisations also engage with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC).

The review highlighted that efforts are made to commission training for individual staff members, when requirements within their scope of practice have been identified at annual appraisal.

All registered nurses and midwifes are assigned to a senior member of the nursing/midwifery teams for induction, supervision, facilitation and critical companionship. On commencement of employment, each nurse/midwife is issued with an induction folder which contains a comprehensive training matrix.



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## 2.2.3 Social Work Profession

### Registration of the Social Care Workforce

The review found that HSC organisations welcomed the DoH decision to introduce compulsory registration of the whole social care workforce on a phased basis. Social workers have been required to register with the NISCC since 2005 and there has been a programme of roll out to 30,000 social care workers since 2009. It is anticipated the final groups of social care workers will be registered with the NISCC by March 2017. RQIA was informed that there is a differentiated approach to the registration and regulation of social workers and social care workers reflecting the differences in qualifications, training, levels of autonomy, responsibility, employment patterns and salary level with domiciliary care workers among the lowest paid within the social care family.

Whilst the review examined governance arrangements solely within HSC, the review team acknowledged that approximately two thirds of the social care workforce is employed in the independent sector (i.e. the voluntary and private sectors). The review team was provided with evidence that the roll out of compulsory registration has been to all social workers and social care workers irrespective of sector. Roll out of compulsory registration to social care workers has been on the basis of 'employed within prescribed settings', all of which are services regulated by RQIA.

### Appraisal, Knowledge and Skills Framework (KSF) and Supervision

Annual appraisal for social care staff is undertaken through the Knowledge and Skills Framework (KSF), and a Personal Development Plan (PDP) is developed which addresses the particular needs of employees. All social work staff are expected to adhere to the DoH policy and standards for professional supervision of social workers. HSC organisations also have their own policies/procedures for supervision of social care workers in line with Minimum Care Standards for regulated settings[10].

Social workers and managers of social care settings are required to re-register every three years. All other social care workers are required to re-register every five years. All registrants are required to complete 90 hours of post registration training and learning within each registration period.

HSC Trusts are required to report to the HSC Board on the provision of professional supervision for social workers as part of Delegated Statutory Functions reporting and accountability arrangements. HSC Trusts also have arrangements in place for the completion of the Person-Centred Planning (PCP) and PDP processes. For example, individual Directorate Performance Scorecards incorporate data on PCP/PDP performance.

[10] https://www.health-ni.gov.uk/articles/care-standards



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Directorate Accountability Reviews address Directorate scorecard returns including PCP/PDP completion.

HSC Organisations operate an appraisal and supervision policy for social workers in line with the DoH policy and standards for professional supervision of social workers. HSC organisations also have their own internal policy/procedures on supervision for social care workers in line with Minimum Care standards of regulated social care settings and what is required.

RQIA found a strong culture of supervision within social work. For all professionally qualified social workers this takes place on a monthly basis in a one to one session; however, for social care workers a mixed approach to supervision exists.

The Improving and Safeguarding Social Wellbeing: A Strategy for Social Work[11] sets out an agenda to strengthen the effectiveness of social work in improving outcomes for service users. One of the priorities of the Strategy is to ensure that professional governance arrangements, including professional supervision, support social workers to work to consistently high standards and manage risks effectively

## Support, Education & Learning

The review found that HSC organisations have systems of governance and leadership to manage and deliver education, training, and CPD opportunities for Social Workers and Social Care Workers. For example, HSC trusts have dedicated Social Services Workforce Development and Training Teams which deliver the Personal Social Services Education and Training Strategy'[12], which provides a framework for education, training and continuous professional development opportunities.

Under the Scheme of Delegation for Statutory Functions, HSC trusts are required to maintain the training standards of their social care workforce, and to continue to address and meet strategic objectives and targets for training as set out by the DoH in Circular HSS (OSS) 1/2010 & 3/2012, and in the NISCC: "General Guidance Document for social work registrants and PRTL Requirements"[13].

The Post Qualifying framework, now renamed Professional in Practice (PiP)[14] Framework for Social Work Professional Development, supports social workers to comply with post-registration requirements and to gain recognition of their learning throughout their careers against a set of professional standards. For the vocational workforce, some HSC trusts have developed a Qualification and Credit Framework (QCF) Strategy 2015.

[11] http://www.niscc.info/storage/resources/2012april_dhssps_socialworkstrategy2012-2022_afmck1.pdf
[12] http://www.niscc.info/files/Workforce%20Development/2006_PSS_TrainingStrategy.pdf
[13] http://www.niscc.info/files/2012Jun_PRTLGuidanceforSocialWorkers.pdf
[14] http://www.niscc.info/files/PiP/Stepped_Booklet_web.pdf



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The review found that there has been significant progress in areas such as the Domiciliary Care workforce with significant numbers of staff achieving the Level 2 award in End of Life Care. These frameworks ensure that staff are developed and practising in line with national occupational standards (NOS)[15].

The review also found that HSC Trusts target training towards particular groups, based on monitoring of adherence to strategic targets, which are reported on an annual basis to the HSC Board. HSC Trusts use this information to target training at particular groups to ensure that resources are being used effectively. The HSC Trusts have also developed a Post Qualifying Policy for social workers only, which specifies the roles and responsibilities of staff, line managers and training teams.

The review team was informed that the Circular HSS (OSS) AYE 2/2015[16] (Assessed Year of Employment of Newly Qualified Social Workers) states 'All newly qualified social workers should be clearly identified as such in the Human Resources information system in order that individuals can be tracked through to successful completion (of their AYE)'. There are also references to supervision, induction, professional development and performance appraisal of newly qualified social workers in this Circular.

[15] http://nos.ukces.org.uk/Pages/results.aspx?u=http%3A%2F%2Fnos%2Eukces%2Eorg%2Euk&k=Social%20Work
[16] http://www.niscc.info/storage/resources/2015_dhssps_aye_circular.pdf



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## 2.2.4 Pharmacy Profession

### Generic Governance Arrangements

In the organisations that were the focus of this review, the review team acknowledged that pharmacy professionals work in well-established regulated environments. Governance arrangements, systems and process are embedded within the pharmacy culture, and are seen as a core part of their functions.

### Future Registration and Regulation of Pharmacy Technicians

Within Northern Ireland, pharmacy technicians are not required to register with the Pharmaceutical Society Northern Ireland (the Society) which is the regulatory body for pharmacists in Northern Ireland. In the rest of the United Kingdom technicians are required to register with the General Pharmaceutical Council (GPhC). The review found that both pharmacists and pharmacy technicians would welcome registration and regulation as it would recognise technicians as professional members of the pharmacy team. It would also provide a number of benefits for the technician, pharmacist and most importantly, service users.

Registration of technicians will contribute to improved patient safety by ensuring only those qualified, competent and under a duty to maintain high standards can work as pharmacy technicians. For example, it will allow technicians to up-skill in order to take on greater responsibilities and work within a structured career pathway. It will also allow pharmacists to delegate roles without fear of legal sanction and release time for pharmacists to deal with more patient facing activities. This may have an additional impact in reducing pressures on other parts of the health service. The review team was informed that a public consultation closed on 14 June 2016 in relation to the future functions of the Society. This included consideration of the registration and regulation of pharmacy technicians.

The DoH continues to take a considered approach to the issue of regulating pharmacy technicians in Northern Ireland. RQIA was informed that there will be a process of consultation and legislative change before any decisions to statutory regulate technicians is progressed.

### Appraisal, KSF and Continuing Fitness to Practise

The review found that HSC organisations have systems and clinical governance processes in place to support their pharmacy staff with their KSF/appraisal and continuing fitness to practise requirements.

Registered pharmacists are required to complete 30 hours of CPD annually to maintain their registration with the Society. Pharmacists in the hospital service would welcome protected CPD time within work, rather than having to complete 30 hours in their own time.



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For pharmacists, confirmation that CPD has been completed, submitted and passed is obtained during an annual appraisal to ensure continuing fitness to practise, as stipulated in the Society requirements. The Society publishes a list of pharmacists removed from its register and this list is checked against pharmacy staff employed by the organisation by pharmacy administration staff. Administration staff also check the register on a regular basis to ensure that all pharmacists are registered. Pharmacists are encouraged to avail of learning and development opportunities offered by both their organisation and the Northern Ireland Centre for Pharmacy Postgraduate Learning and Development (NICPLD).

The review team was provided with instances were pharmacists present a subject from their area of expertise at monthly clinical pharmacy meetings, which provides a CPD opportunity for colleagues. Occasionally a member of the trust consultant staff may also present at such a meeting, on a topic of interest to those attending.

As pharmacy technicians are not registrants, they are not required to complete a specific amount of annual CPD; however, within trusts, technicians are encouraged to avail of learning and development opportunities offered by the trust or by NICPLD. Whilst NICPLD workshops are no longer available for technicians they are encouraged to complete distance learning packages available to them.

### Rebalancing Legislation & Consultation on the Future Functions of the Pharmaceutical Society Northern Ireland

A possible outcome of existing legislation is that a pharmacist may face criminal prosecution for a single dispensing error. This has long been a concern for pharmacists within Northern Ireland, and could also impact on future registered pharmacy technicians. Removing this barrier will help encourage a more open approach to error and near miss reporting, improve learning and promote a more transparent culture with ultimate benefits for patient safety.

The government is proposing a new defence against criminal prosecution for pharmacy professionals if they make an inadvertent dispensing error, subject to certain conditions. As a result, in February 2015, the Government launched a Consultation regarding the Rebalancing Medicines Legislation & Pharmacy Regulation[17], and sees the proposals set out in the consultation as a positive step towards a modern approach to healthcare regulation. The review team was informed that the DoH is already prioritising and progressing this work with regard to Northern Ireland.

During the review concerns were raised that having both the GPhC and the Society as regulators of a single professional body results in inconsistencies in approach. It also means that a pharmacist moving between jurisdictions

[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403387/consultation_doc.pdf



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has to register with another entity and that any pharmacist working in both jurisdictions requires dual registration. The possibility of having a single pharmaceutical regulator for the whole of United Kingdom was welcomed.

## 2.2.5 Dental Profession

The review team acknowledged that the dental profession works in well-established regulated environments. Governance arrangements, systems and processes are embedded within the dental culture, and are seen as a core part of their functions. Both dentists and dental care professionals are required to register with the GDC. RQIA was advised that the registration of dental care professionals was viewed very positively by the profession.

### Governance Arrangements and Structure of Community Dental Services

Within Northern Ireland there are two major branches of the dental profession (general dental practitioners sit outside the trust structures as independent practitioners):

1. Hospital Consultant Dental Service – based at the School of Dentistry (Royal Victoria Hospital, Belfast), Ulster Hospital (Dundonald), and Altnagelvin Hospital.

2. Community Dental Service – based at Health Centres and Health and Well-being centres across Northern Ireland.

In December 2014, RQIA published a report of a review of the Implementation of the Dental Hospital Inquiry Action Plan. That review assessed progress against the 45 recommendations contained in a report of an inquiry chaired by Mr Brian Fee QC. The action plan included many aspects that were to be assessed by this review of governance arrangements to support professional regulation and the review team considered that in light of this, it would not be necessary to include the School of Dentistry in this review.

The majority of Oral and Maxillofacial services in the Ulster and Altnagelvin Hospitals are provided by consultant staff who are both dentally and medically qualified. Although there are a number of singly qualified practitioners, the review team considered that the main issues for these services would be covered by the medical section of the report. This section of the review therefore concentrates on the community dental service provided by HSC Trusts.

### Appraisal and Continued Professional Development (CPD)

The review found that all HSC organisations have systems of appraisal and clinical governance within their organisation. CDS Dentists undergo annual appraisal using a Regional Community Dental Service Appraisal Document in Northern Ireland. HSC organisations also ensure mandatory training is completed in line with organisational requirements.



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Registered dentists are required to complete 250 hours of CPD every five years. At least 75 of these hours need to be 'verifiable' CPD. Dental Care Professionals must carry out at least 150 hours of CPD every five years. At least 50 of these hours need to be 'verifiable' CPD. CPD hours may be completed within working hours in HSC Trusts, especially for DCPs. Much of dentists' CPD is carried out in their own time. Dentists and DCPs would welcome protected CPD time within work, rather than having to complete these hours in their own time.

In addition, dentists in the CDS are funded to attend 21 study days over three years; however, as there is no funding for backfill, dentists find it difficult to attend. Study leave is granted to attend CPD appropriate to their job role. CPD attainment is checked during the appraisal process. Dental Care Professionals also undergo annual appraisal through the KSF framework.

Registered dentists and dental care professionals have a responsibility as individuals to maintain their own CPD. Dentists and DCPs make an annual self-declaration that they comply with CPD requirements as part of registration with the GDC.

## 2.2.6 Biomedical Science Profession

### Governance Arrangements and Structure of Biomedical Medical Science

During this review, RQIA visited the Northern Ireland Blood Transfusion Service (NIBTS). The NIBTS is an independent agency which employs a number of biomedical scientists, Medical Laboratory Assistants and Laboratory Assistants.

The review team acknowledged that biomedical scientists and laboratory assistants within Northern Ireland work in well-established regulated environments, and are registered, regulated and inspected by a number of organisations such as, the Health and Care Professions Council (HCPC), The Medicines and Healthcare products Regulatory Agency (MHRA), and The Institute of Biomedical Science (IBMS).

### Appraisal and Continued Professional Development (CPD)

The review found that the appraisal process within the NIBTS for biomedical scientists is organised and guided by their HR department, in line with the KSF framework.

Biomedical scientists are required to renew their registration every two years; in order to do this they must prove they have fulfilled the HCPC CPD requirements. These requirements are set out in a series of guidelines to improve professional development and patient care; however, no specific number of hours or course requirements are stipulated. Registrants are expected to keep a record of their own CPD and this is monitored through an HCPC audit of a random selection.



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The review team was informed that the IBMS runs a similar system to the CPD scheme for biomedical scientists. They must achieve 250 CPD credits within five years. These credits are not based on hours; they are achieved by completing a variety of activities, each worth a certain number of credits, such as, attending a lunchtime seminar, giving a lecture/presentation to students or attending a conference. Once 250 credits have been achieved, the biomedical scientists will then submit an application for CPD validation to the IBMS, and achieve a diploma. The review team was informed that this is how the current scheme operates; however, the IBMS is moving to a new CPD scheme in summer 2016[18]. The IBMS CPD scheme encourages members to maintain, improve and extend their knowledge, skills and practice for the purpose of maintaining CPD.

Each biomedical scientist within the NIBTS undergoes an annual appraisal in the form of a 'Staff Development Review' (SDR) with their line manager. During this review, staff discuss training and/or CPD requirements they may have. Following this, a Personal Development Plan (PDP) is developed for each individual. On completion of departmental SDRs a Team Development Plan is then formulated, and these are used to complete a Corporate Training Needs Analysis.

During the SDR, staff may also add further personal objectives, for example, post entry qualifications, attendance at specific courses and conferences or participation in user groups, all of which will contribute to their CPD activities. Bi-monthly departmental meetings are held which also provide staff with a forum to discuss and share any CPD activities, concerns or suggestions.

The review also found that the NIBTS has the following recognised supervisors/trainers who deliver education, training and complete annual appraisal reports for individual biomedical scientists:

- A dedicated Laboratory Training Officer
- Two qualified IBMS Registration Portfolio verifiers
- Four University of Ulster trained mentors for placement students
- All HCPC registered staff will supervise training of trainee biomedical scientists and placement students to varying degrees depending on their job role.
- Annual appraisals for biomedical scientists and medical laboratory assistants are carried out by their line-manager, Deputy Head, or Head of Department depending on grade of staff.

[18] https://www.ibms.org/go/practice-development/cpd



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## Education and Learning

The review found that the NIBTS has systems and processes in place to manage and deliver education, training and learning opportunities for biomedical scientists.

The educational processes for laboratory staff take the form of on-going continuous improvement. This is led by the laboratory training officer and includes a programme of lunchtime seminars, mentoring for university placement students and a three yearly Quality Systems training programme, overseen by the Regulatory Affairs & Compliance department. In addition to this, all staff participate in their own individual CPD activities.

The Laboratory Manager is responsible for the management and professional development of all departmental staff. The Laboratory Manager delegates this role to the laboratory training officer and in cooperation with the laboratory training officer, will develop effective programmes of training for all laboratory staff and placement students.

The laboratory training officer develops induction programmes for all new members of staff and placement students and prepares a training plan for each member of staff/placement student. Each Department Head is responsible for delivery of training within his/her department and must ensure that training of biomedical scientists is delivered by HCPC registered staff.

NIBTS has been approved by IBMS as a training laboratory for pre & post registration Biomedical Scientists, and has the following systems and processes in place:

- Laboratory Training and Competency Policy
- Laboratory Training and Competency Procedure
- Corporate Induction Manual
- Laboratory Training Programme

Biomedical scientists have a responsibility to maintain a portfolio of Continuous Professional Development (CPD) in line with the requirements of the HCPC. This is subject to periodic review by the HCPC. In line with the 'Policy and Procedure for the Maintenance of Professional Registration', each biomedical scientist has a responsibility to ensure that HCPC registration is maintained.



Received from SHSCT on 27/09/2022. Annotated by the Urology Services Inquiry.

## Chapter 3: Conclusions

During this review, RQIA found robust clinical and social care governance arrangements within HSC organisations that support professional regulation. Organisations adhere to the requirements, standards and guidelines set internally and by Professional Regulatory Bodies to assure services users, carers and families that professional staff employed are fully fit to practise.

The review found that all eight HSC organisations involved in this review function in well-established regulated environments, with robust governance arrangements in place to assure essential requirements for registration and regulation are adhered to.

RQIA found that HSC organisations have engaged effectively with professional regulatory bodies such as the GMC, NISCC, NMC, GDC, The Society, and HCPC. Good links have been established to ensure continued registration of staff and HSC organisations are now informed in a timely manner of changes in guidelines. There is now effective joint working when dealing with concerns regarding underperforming staff and effective support is provided by regulatory bodies where appropriate. Some regulatory bodies however are perceived by staff to be more successful than others by virtue of local presence, provision of local engagement opportunities and provision of readily available professional guidance support and are perceived to provide better value for the annual retention fee paid.

RQIA was advised that a number of national and local initiatives are currently underway, for example, the intended UK-wide government consultation to explore reform of healthcare professional regulation. This will consider development of a national framework to assess which professional groups should be regulated and how. It is anticipated that the future direction of professions subject to professional regulation will be impacted by these initiatives. The review team considers that this needs to be accounted for during any review that takes place.

RQIA found strong commitment among HSC organisations to take forward professional registration and regulation of their workforce in Northern Ireland. This is an important element in providing assurance to the general public that the HSC workforce is fit for purpose and will continue to provide a high standard of care.



Received from SHSCT on 27/09/2022. Annotated by the Urology Services Inquiry.

## Appendix 1: Abbreviations Used

| | |
|---|---|
| AHP | Allied Health Profession |
| AYE | Assessed Year in Employment |
| Belfast Trust | Belfast Health and Social Care Trust |
| BSO | Business Service Organisation |
| CDS | Community Dental Service |
| CEC | Clinical Education Centre |
| CNO | Chief Nursing Officer |
| CoDEG | Competency Development and Evaluation Group |
| CPD | Continuing professional development |
| DATIX | Healthcare Incidents, Patient Safety & Risk Management Software |
| DCP | Dental Care Professional |
| DoH | Department of Health, Northern Ireland |
| GDC | General Dental Council |
| GMC | General Medical Council |
| GP | General Practitioner |
| GPhC | General Pharmaceutical Council |
| HCPC | Health and Care Professions Council |
| HR | Human Resource |
| HRPTS | Human Resources, Payroll, Travel and Subsistence System |
| HSC | Health and Social Care |
| HSC Board | Health and Social Care Board |
| HSC Trusts | Health and Social Care Trusts |
| IELTS | International English Language Testing System |
| LD | Learning Disability |
| LTO | Laboratory Training Officer |
| MH | Mental Health |
| MHRA | Medicines and Healthcare Products Regulatory Agency |
| MLA | Medical Laboratory Assistant |
| M&M | Morbidity and Mortality |
| NCAS | National Clinical Assessment Service |
| NIAO | Northern Ireland Audit Office |
| NIAS | Northern Ireland Ambulance Service |
| NIBTS | Northern Ireland Blood Transfusion Service |
| NIMDTA | Northern Ireland Medical and Dental Training Agency |
| NIPEC | Northern Ireland Practice and Education Council |
| NISCC | Northern Ireland Social Care Council |
| NMC | Nursing and Midwifery council |
| NOS | National Occupational Standards |
| Northern Trust | Northern Health and Social Care Trust |
| NVQ | National Vocational Qualification |
| OCN | Open College Network |
| PALs | Procurement and Logistics Service |
| PDP | Personal Development Plan |
| PHA | Public Health Agency |
| PIP | Professional in Practice |



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| | |
|---|---|
| Prep | Post-registration education and practice |
| PRTL | Post registration training and learning |
| The Society | Pharmaceutical Society Northern Ireland |
| QCF | Qualification and Credit Framework |
| QUB | Queens University |
| RO | Responsible Officer |
| RPS | Royal Pharmaceutical Society |
| RSSRS | Regional Shared Services Recruitment |
| SAI | Serious Adverse Incident |
| SBAR | Situation, Background, Assessment and Recommendation |
| SDR | Staff Development Review |
| SLA | Service Level Agreement |
| South Eastern Trust | South Eastern Health and Social Care Trust |
| Southern Trust | Southern Health and Social Care Trust |
| SCD | Special Care Dentistry |
| TOR | Terms of Reference |
| UUJ | University of Ulster |
| Western Trust | Western Health and Social Care Trust |



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The **Regulation** and
**Quality Improvement**
**Authority**

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@RQIANews

Assurance, Challenge and Improvement in Health and Social Care

Received from SHSCT on 27/09/2022. Annotated by the Urology Services Inquiry.

particular initiative, other than the monitoring plan, or the action plan as we call it, to get to grips with him. Is that the way it would be dealt with today?

A. The attempts that had been made were through job planning process, appraisal process, the usual governance procedures that are in place for doctors and, again, the history with Mr. O'Brien had been that there was delays in all of those systems, in that, you know, it took him a while to get to actually undertake his appraisal, the job plans he was very tardy in signing off, all of those things. So there was something about, you know, the conversations that were had with him weren't landing him where he needed to be. There was always more work to be done, there was always more information that had to be brought to bear to improve in all of this, and the deadlines just kept getting pushed back and back. Right. So that, together with the discussions that were there, suggested to me, you know, together with the fact that he had been through a Maintaining High Professional Standards Investigation... 10:32 10:33 10:33 10:33

CHAIR: I think we have a tendency to speak quickly, but if we can slow down, because not only the stenographer has to get everything you say, but we have to try and keep a note as well. So if you can slow down, please, doctor. 10:33

MR. WOLFE: So, yes, you were saying - you were taking us through the various conventional governance steps in respect of Mr. O'Brien and you were pointing out delay

## 8. Any other points

Aidan is the Principal Investigator at Craigavon Area Hospital of an international study into a new drug treatment for Angiomyolipoma (Ref 09/H0502/82).

IV fluids/Antibiotic issue

Aidan has regarded the changes resulting from the ward reconfigurations of 2009 as particularly disruptive, since it had taken many years to build and had predicted the deleterious effects of such changes. Eventual restoration to a definitive urology unit has been a very important point, and for the Trust to recognise this precise point.

A further major change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon Area Hospital, and negative consequences for patients. There is general discontentment in the decision making process conducted by the recent Regional Review of Urology. Aidan has concerns that this will have significant knock on effects for services in the area in the future.

Action agreed:

IV fluids/Antibiotic issue has been improved by a new care-pathway defined by the Trust.

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

# ANNUAL APPRAISAL 2010 MR. AIDAN O'BRIEN

## FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

## SUMMARY OF APPRAISAL DISCUSSION

### 1. Good medical care

Commentary:

Aidan qualified in 1978, holds full GMC registration and has been in the same Consultant Urologist post since 1992. He is a Fellow of the RCS in Ireland, and is a member of several general and urological societies. Description of his job reflects a broad urological practice. This includes MDM oncology involvement and a special interest in lower urinary tract dysfunction. Current rota is 1:3. The population base covered is geographically wide, and hence patients are from both urban and rural backgrounds.

A log of individual list of operations performed for 2008, 2009 and 2010 is impressively long, defining a constant and hard working pattern.

No formal complaints nor critical incidents are logged by the Trust. The Trust however has had discussions with reference to patients being treated with IV fluids and antibiotics. This has been satisfactorily concluded.

An audit of prostate biopsy outcomes is recorded. Several of the hospital mandatory courses have been attended.

Action agreed: For next appraisal

- log of total volume of outpatient activity, day cases and operations.
- audits in current time frame
- log Defence Organisation
- formally log mandatory courses

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust
*Quality Care - for you, with you*

# APPRAISAL DOCUMENTS

## CONTENTS



## FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information – click here to navigate to the relevant guidance in Appendix 4 of these forms.*

| | | |
|---|---|---|
| 1.1 | Full name | Aidan O'Brien |
| 1.2 | GMC Registered address (contact address if different) | Personal Information redacted by the USI |
| 1.3 | Main employer | Southern Health and Social Care Trust |
| 1.4 | Main place of work | Craigavon Area Hospital, Craigavon |
| 1.5 | Other employers/ places of work | Armagh Community Hospital, Armagh<br>South West Acute Hospital, Enniskillen |
| 1.6 | Date of primary medical qualification | December 1978 |
| 1.7 | GMC registration number and type | Personal Information redacted by the USI Full with Specialist Registration |
| 1.8 | Start date of first substantive appointment in HSC as a trained doctor | 06 July 1992 |
| 1.8 | GMC Registration date and specialties | 07 August 2013 Urology |
| 1.9 | Title of current post and date appointed | Consultant Urological Surgeon on 11 June 1992 |
| 1.10 | For any specialist registration / qualification outside UK, please give date and specialty | Fellow of Royal College of Surgeons in Ireland November 1983 |
| 1.11 | Please list any other specialties or sub-specialties in which you are registered | None |
| 1.12 | Is your registration currently in question? | No |
| 1.13 | Date of last revalidation (if applicable) | 28 April 2014 |
| 1.14 | Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts) | Consultant Urological Surgeon, Craigavon Area Hospital |


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**ANY ADDITIONAL INFORMATION**

I became a

- Fellow of the Ulster Medical Society in 1984
- Fellow of the Royal Society of Medicine in Ireland in 1986
- Fellow of the Irish Society of Urology in 1992
- Member of the Bristol Urological Institute in 1992
- Director of CURE in 1995
- External Adviser to the Royal College of Surgeons in Ireland in 2012 for Specialist Registrar appointments in Republic of Ireland
- Lead Clinician of Urological Cancer Multidisciplinary Team of the Southern Health and Social Care Trust in April 2012
- Lead Clinician and Chair of the Northern Ireland Cancer Network Clinical Reference Group in Urology in January 2013
- Peer Reviewer for the National Cancer Plan in February 2015



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## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

***Click here to navigate to the relevant guidance in Appendix 2.***

| | |
|---|---|
| 2.1 Please give a short description of your work, including the different types of activity you undertake | My work includes the clinical and operative management of acute urological admissions and referrals, in addition to the ongoing clinical management of all elective admissions, when urologist of the week, which pertains for one week in every six weeks. Otherwise, it includes the administrative, clinical and operative management of elective inpatient and day case surgery, flexible cystoscopy lists and urodynamic studies, new patient clinics, general and oncology review clinics. |
| 2.2 List your main sub-specialist skills and commitments / special interests | Urological oncology.<br>Lead Clinician of the Urology MDT.<br>Chair of Urology MDM.<br>Acute Urology.<br>Lower urinary tract dysfunction.<br>Paediatric Urology |
| 2.3 Please give details of any emergency, on-call and out of hours responsibilities | Since the introduction of 'Urologist of the Week' in September 2014, one consultant is responsible for all acute urological management for the Southern Health and Social Care Trust population, and for that of County Fermanagh, in addition to all referrals from Daisy Hill and South West Acute Hospitals. As one of six consultants, I participate in this rota. In addition to acute urology, it also includes the ongoing clinical management of patients electively admitted. During 2016, I also continued to provide support to Mr. Suresh when he was 'urologist of the week' until he left our department in October 2016.. |
| 2.4 Please give details of out-patient work if applicable | On Mondays, I conduct review clinics, rotating through Armagh Community , South West Acute and Craigavon Area Hospitals. On Tuesdays, I conduct a New Patient clinic at Craigavon Area Hospital. On Fridays, I conduct an Oncology Review Clinic concurrent with Urodynamic Studies. |
| 2.5 Details of any other clinical work | I triaged Red Flag referrals while 'urologist of the week'.<br>I arranged inpatient and day case surgical admissions.<br>I arranged flexible cystoscopy and urodynamic lists.<br>I arranged oncology review clinics.<br>I reviewed, and amended if necessary, all outcomes of the weekly urological MDM, ensuring all reviews of all consultants were conducted within required timeframes. |
| 2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? Please give details including:<br>▪ Number and type of cases.<br>▪ Any audit or outcome data for the private practice.<br>▪ Details of any adverse events, critical incidents.<br>▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues | I do not have admission rights to, or practising privileges in, any non-HSC hospitals or clinics<br>I do conduct a private outpatient consultation practice at my home.<br>I had 75 consultations during 2016.<br>I have never had a complaint, adverse events or incidents arising out of private practice.<br>I have continued to keep all private consultation records for a minimum period of three years, all correspondence has been filed in patients' hospital charts. |



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| | |
|---|---|
| 2.7 List any non-clinical work that you undertake which relates to teaching | Clinical Supervisor of Specialist Registrars in Urology |
| 2.7.1 List any non-clinical work that you undertake which relates to management | As Lead Clinician of the Urological cancer MDT, I liaised with the Cancer Coordinator and Tracker eack week to ensure that the management of all urological cancer patients was progressed during the 31 and 62 day timelines.<br>Having achieved 100% compliance during the year of Peer review in 2015, I ensured that remained the case during 2016.<br>I held Urology MDM Business meetings in preparation for the Annual Report to the National Cancer Plan in September 2016. |
| 2.7.2 List any non-clinical work that you undertake which relates to research | None |
| 2.7.3 List any work you undertake for regional, national or international organisations. | Lead Clinician and Chair of the Northern Ireland Cancer Network Clinical Reference Group in Urology 2013 - 2016 |
| 2.7.4 Please list any other activity that requires you to be a registered medical practitioner | Provision of expert medicolegal reports |

## CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

Job Plan enclosed

## ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The only change in all of the factors which have impacted negatively upon the delivery of care to patients, particularly those most urgently in need, has been that they have worsened. My main concerns during 2016 were

- the suboptimal care delivered to acute admissions and referrals, due to lack of beds and lack of emergency operating capacity, the lack of elective operating
- the lack of elective operating capacity resulting in waiting lists becoming larger and longer
- the increasing number of patients waiting longer periods beyond expected review dates.



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# HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

*Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP*

### DOMAIN 1 - Knowledge, Skills and Performance

**Attribute: 1.1 Maintain your professional performance**
**Attribute: 1.2 Apply knowledge and experience to practice**
**Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.**

| | List of Supporting Information | Applicable Date |
|---|---|---|
| 1 | Entry on the Specialist Register of the General Medical Council | 07 August 2013 |
| 2 | GMC Revalidation Details | 28 April 2014 |
| 3 | Certificate of Proof of Entry on GMC Register | 18 December 2016 |
| 4 | Annual GMC Retention Fee Confirmation | 16 February 2017 |
| 5 | Job Plan commencing 01 October 2016 | 01 October 2016 |
| 6 | CLIP Report January 2016 to December 2016 | 2016 |
| 7 | Elective Inpatient Operating 2016 | 2016 |
| 8 | Clinics in 2016 | 2016 |
| 9 | CLIP Structured Reflective Template | 2016 |
| 10 | Mandatory Training Passport | December 2016 |
| 11 | Personal Development Plan 2016 | December 2016 |
| 12 | PDP Structured Reflective Template | November 2017 |
| | | |
| | | |

**Discussion**

Mr O'Brien has continued to deliver an excellent service in urology. He was lead Clinician in urology until December 2016 and helped oversee improvements in urological Cancer service. His CPD has faltered due to issues beyond your control. His mandatory training is up to date. His job plan is very heavy.

**Actions Agreed**

(1) Focused CPD to keep up to date.

(2) Reflect on job plan with line manager and discuss issues.

CLICK HERE for further guidance about completing Form 3 and HERE for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.



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# HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

*Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP*

## DOMAIN 2 - Safety and Quality

**Attribute: 2.1 Contribute to and comply with systems to protect patients**
**Attribute: 2.2 Respond to risks to safety**
**Attribute: 2.3 Protect patients and colleagues from any risk posed by your health**

| | List of Supporting Information | Applicable Date |
|---|---|---|
| 1 | Record of attendance at Morbidity and Mortality Meetings 2016 | 2016 |
| 2 | Incident Report | 21 October 2016 |
| 3 | Statement of General Practitioner | June 2016 |
| 4 | Inoculation History | November 2008 |
| 5 | Health and Probity Forms | November 2017 |
| 6 | Certificate of Membership of Medical Protection Society | 01 September 2017 |
| 7 | Urology MDT Annual Report for January – December 2016 | 01 September 2017 |
| 8 | Other Roles Structured Reflective Template | November 2017 |
| 9 | Letter of Concerns | 23 March 2016 |
| 10 | | |
| | | |
| | | |
| | | |
| | | |

**Discussion**

Mr O'Brien clears M&M meetings and is committed to health improvement. All aspects of his practice are audited. His attendance at M & M is 50%. ~~and~~ excluding regional meeting which will bring up to recommended attendance guidelines letter of concern regarding administrative issues.

**Actions Agreed**

To continue his commitment to safety and quality.

To help the Trust address their concerns regarding his administration.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.



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# HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

*Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP*

## DOMAIN 3 - Communication, Partnership and Teamwork

**Attribute: 3.1 Communicate effectively**
**Attribute: 3.2 Work constructively with colleagues and delegate effectively**
**Attribute: 3.3 Establish and maintain partnerships with patients**

| | List of Supporting Information | Applicable Date |
|---|---|---|
| 1 | Letter of Appointment as Clinical Lead for Urology MDT | 10 April 2012 |
| 2 | Notification of MDT Business meetings | February 2016 |
| 3 | Urology MDT Annual Report for January – December 2016 | 01 September 2017 |
| 4 | Reflective Template on Role of Lead Clinician of Urology MDT | 30 November 2017 |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
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| | | |
| | | |

**Discussion**

Mr O'Brien Chairs MDT meeting until December 2016. This is now done on a rotational basis with 2 colleagues. This multidisciplinary meeting caters with all aspects of the urological cancer patient. Mr O'Brien communicates with staff regarding specific concerns about particular patients

**Actions Agreed**

- To continue commitment to the multidisciplinary process.
- To continue excellence in communication with colleagues regarding patient care.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.



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# HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

*Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP*

## DOMAIN 4 - Maintaining Trust

**Attribute:4.1 Show respect for patients**
**Attribute:4.2 Treat patients and colleagues fairly and without discrimination**
**Attribute:4.3 Act with honesty and integrity**

| | List of Supporting Information | Applicable Date |
|---|---|---|
| 1 | Signed probidity declaration | |
| 2 | Signed health declaration | |
| 3 | Thankyou cards from patients | |
| 4 | Reflective Templates | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
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| | | |
| | | |
| | | |

**Discussion**

Mr OBrien has signed his probidity and health declaration Mr OBrien enjoys good health and was off for 2 months for an operative procedure. His leave record is within trust guidelines. He always treats patients with dignity and respect and will always acting with honesty and integrity.

**Actions Agreed**

Mr OBrien will continue to act with honesty and integrity he will give a commitment to seek help at the earliest opportunity should any medical or other issues arise.

**CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates**

**To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.**



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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

**Review of last year's Personal Development Plan**

| Development needs | Actions agreed | Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved? |
|---|---|---|
| To address in a durable and effective manner my long waiting list, and in so doing, to reduce the inequity in waiting lists. | A Trust issue to be discussed and agreed | No. Even though I conducted additional operating sessions that were made available, there was no additional effort or strategy by Trust management to address the issue. |
| To address long waiting list for urological cancer reviews | A Trust issue to be discussed and agreed | No. As above |
| To reduce the numbers of new patient consultations | A Trust issue to be discussed and agreed | No. Politically unacceptable |
| Attend course in Urology | To attend Annual Meeting of Irish Society of Urology | Attended September 2016 |
| | | |
| | | |
| | | |



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## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| PERSONAL DEVELOPMENT PLAN for the year ahead | | |
|---|---|---|
| **Development needs** | **Actions agreed** | **Target dates** |
| To continue to dictate letters following every outpatient consultation | Addressing letter of Concern | December 2017 |
| To continue to triage all referrals | Addressing letter of Concern | December 2017 |
| To discuss issues relating to a heavy Job plan. | Discuss with line manager. | July 2018 |
| To attend an international meeting on urology | Attend meeting - ? EAU. | December 2017 |
| | | |
| | | |
| | | |
| | | |

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## FORM 5- HEALTH AND PROBITY STATEMENTS

## HEALTH DECLARATION

*To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.*

### Professional Obligations

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: Personal Information redacted by the USI Date: 30 November 2017

Name in Capitals: Aidan o'Brien

***NB: Additional Health and Probity forms are on the Southern Docs website – click here***

**Regulatory and Voluntary Proceedings** *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

**OR**

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: Personal Information redacted by the USI Date: 30 November 2017

Name in Capitals: Aidan O'Brien



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## PROBITY DECLARATION

### Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006).*

Signature: [redacted] Date: 30 November 2017

Name in Capitals: Aidan o'Brien

**Convictions, findings against you and disciplinary action** *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

**OR**

☐ If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: [redacted] Date: 30 November 2017

Name in Capitals: Aidan O'Brien

## INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click here

Signature: [redacted] Date: 30 November 2017

Name in Capitals: Aidan O'Brien



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 6 - SIGN OFF

*Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.*

| CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS | APPRAISER SIGNATURE | DATE |
|---|---|---|
| | | |
| | | |
| | | |

When you have completed the appraisal, the appraiser should check and sign the following:

| GMC REQUIRED INFORMATION | | | PRESENT |
|---|---|---|---|
| Continuing professional development | | | Personal Information redacted by the USI |
| Quality improvement activity | | | |
| Significant events review | | | |
| Review of complaints and compliments | | | |
| Feedback from colleagues | Year undertaken OR Planned Year: | 2014 | |
| Feedback from patients (where applicable) | Year undertaken OR Planned Year: | 2014 | |

| APPRAISAL CHECKLIST | COMPLETED |
|---|---|
| Check that all sections of the documentation have been completed. | Personal Information redacted by the USI |
| Ensure the previous year's Personal Development Plan has been reviewed. | |
| Forward required Forms according to the organisation's appraisal policy. | |

## APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

**APPRAISEE**

Signature of Appraisee: Personal Information redacted by the USI Date: 01.12.17

**APPRAISER**

Signature of Appraiser: Personal Information redacted by the USI Date: 1/12/2017

GMC Number: _____

**CO-APPRAISER** (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 7- REVALIDATION PROGRESS

*Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.*

### Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2015 has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| | | |
| | | |
| | | |

Signature of Appraiser: [redacted] Name of Appraiser: M. Young

GMC Number: [redacted] Date: 23.12.16.

### Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2016 has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| Investigation of letter of concern | Discussion with Trust. | |
| | | |
| | | |

Signature of Appraiser: [redacted] Name of Appraiser: Damian Scally

GMC Number: [redacted] Date: 1/12/2017

### Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| | | |
| | | |
| | | |

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| | | |
| | | |
| | | |

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

## Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| | | |
| | | |
| | | |

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

## Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

| Current Outstanding Issues: | Action Required | Resolution |
|---|---|---|
| | | |
| | | |
| | | |

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

*Please ensure the section below is fully completed.*

| GMC Supporting Information Requirements | Year Completed | Reviewed by | Date |
|---|---|---|---|
| Feedback from colleagues 1 in 5 years | 2014 | Personal Information redacted by the USI | 1/12/17 |
| Feedback from patients (where applicable) 1 in 5 years | 2014 | | 1/12/17 |
| Significant Events Review | 2016 | | 1/12/17 |
| Review of complaints and compliments | 2016 | | 1/12/17 |
| Continuing Professional Development | 2016 | | 1/12/17 |
| Quality Improvement Review | 2016 | | 1/12/17 |



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## Appendix 1 Education and Training Competencies Available for Medical Staff

| Right Patient, Right Blood | Method | Core / Optional | Date Completed |
|---|---|---|---|
| RPRB Theory (Every 3 years) | Elearning Blood Transfusion Module Click Here | Core | 15/12/15 |
| Competency 1,2 & 4 (Every 3 Years) | Face to face – Trust Haemovigilance Staff Contact Patricia Watt on [redacted] | Core | 16/04/14 |
| Desist Notice | To obtain a desist notice, click here | Core | |

| Annual Updates | Method | Core / Optional | Date Completed |
|---|---|---|---|
| Fire Safety | Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.developmer[redacted] to book a place. | Core | 07/12/15 |
| **2 Yearly Updates** | **Method** | **Core / Optional** | **Date Completed** |
| Infection Prevention and Control | SHSCT E-Learning Module Click Here | Core | 08/10/13 |
| Resuscitation | Face to Face.<br>CAH - Helen Cullen [redacted]<br>DHH - Bernie O'Connor [redacted]<br>Bleep: 1101 [redacted] | Optional | |
| **3 Yearly Updates** | **Method** | **Core / Optional** | **Date Completed** |
| Safeguarding Children & Vulnerable Adults | Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development[redacted] to book a place. | Core | 29/04/14 |
| Information Governance/Data Protection/IT Security | SHSCT E-Learning Module Click Here | Core | 17/04/14 |
| Moving and Handling | SHSCT E-Learning Module Click Here | Core | 13/03/14 |
| Health & Safety / Control of Substances Hazardous to Health (COSHH) | SHSCT E-Learning Module Click Here | Core | 08/10/13 |
| Discovering Diversity | HSC E-Learning Module Click Here | Optional | |
| Recruitment & Selection | HSC E-Learning Module Click Here | Optional | |
| Sickness & Absenteeism Training | Face to Face. Contact ELD on [redacted] or email learning.development[redacted] | Optional | |
| Hyponatraemia | BMJ E-Learning Module Click here | Optional | |
| Management of Actual or Potential Aggression | Face to Face. Contact ELD on [redacted] or email learning.development[redacted] | Optional | |
| Fraud Awareness | HSC E-Learning Module Click here | Optional | |
| Seeking and Obtaining Consent for Hospital Post Mortem Examination | SHSCT E-Learning Module Click here | Optional | |



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| Once off Training | Method | Core / Optional | Date Completed |
|---|---|---|---|
| National Early Warning System | National NEWS e-learning Click here | Optional | |
| Obstetrics Early Warning System | Online Module Click here | Optional | |
| Paediatrics Early Warning System | Face to Face. Contact CAH Dr S Shah [redacted] Contact DHH Dr B Aljarad [redacted] | Optional | |
| Consent | In House E-Learning Module Click here | Optional | |
| Blood Culture | In House E-Learning Module Click here | Optional | |
| Peripheral Line | In House E-Learning Module Click here | Optional | |
| Oral Anticoagulants | MHRA Module Click here<br>Once on the site choose the Anticoagulant Module. On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration. | Optional | |
| Naso Gastric Tube Placement | In House E-Learning module Click here | Optional | |
| Protocol following death of patient | In House E-Learning module Click here | Optional | |
| Guide to Prescribing in SHSCT | In House E-Learning module Click here | Optional | |
| Research and Development - Good Clinical Practice Training | Elearning Module Click here | Optional | |
| VTE | King's Thrombosis Centre E-learning Click here | Optional | |
| Safe Sedation [Module 1,2 & 3] | In House Elearning Modules<br>Click here (Part 1)<br>Click here (Part 2)<br>Click here (Part 3) | Optional | |
| Gastrointestinal endoscopy | Face to Face Contact Dr A Murdock [redacted] | Optional | |
| Chest Drain Insertion | Face to Face<br>Contact Dr A Ferguson [redacted] | Optional | |
| Blood Gas Instrument | Face to Face<br>Contact Derek McKillop [redacted] Face to face | Optional | |
| Appraiser Training | Face to face<br>Dates available here | Optional | |
| Appraisee Training | Face to face<br>Dates available here | Optional | |
| Insertion and Management of Indwelling Urinary Catheters | Online Module Click here | Optional | |
| Coroner's Investigations and Inquests Programme | Online Module Click here | Optional | |
| HIV Awareness Training | Face to Face<br>Contact Lyndsey Hasson<br>Tel: [redacted] | Optional | |
| Patients enrolled in Clinical Trials | In House E-Learning module Click here | Optional | |



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| | | | |
|---|---|---|---|
| Waste Management | SHSCT E-Learning Module Click Here | Optional | |
| **Modules proposed for E-Learning** | **Method** | **Core / Optional** | **Date Completed** |
| Better Communication/Complaint Handling | Face to face | Optional | |
| Incident Reporting | Face to face | Optional | |
| Clinical Negligence | Not currently available | Optional | |

*Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team,* [redacted] Personal Information redacted by the USI

*Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.*

## TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

**APPRAISEE**

Signature of Appraisee: [redacted] Personal Information redacted by the USI

Name of Appraisee: [redacted] Personal Information redacted by the USI

GMC Number: [redacted] Personal Information redacted by the USI

Date: 01.12.17

**APPRAISER**

Signature of Appraiser: [redacted] Personal Information redacted by the USI

Name of Appraiser: [redacted] Personal Information redacted by the USI

GMC Number: [redacted] Personal Information redacted by the USI

Date: 1/12/17



Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

# Mandatory Training Passport

Aidan O'Brien, Urology, Date Record Created 28/12/2017

Print as PDF

## CORE MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FIRE | 24/10/2017 | 24/10/2018 |
| INFECTION CONTROL | 08/10/2013 | 08/10/2015 |
| SAFEGUARDING | 24/10/2017 | 23/10/2020 |
| INFORMATION GOVERNANCE | 17/04/2014 | 16/04/2017 |
| H&S COSHH | 08/10/2013 | 07/10/2016 |
| BACKCARE | 13/03/2014 | 12/03/2017 |
| RPRB DESIST? | | |
| RPRB THEORY | 15/12/2015 | 14/12/2018 |
| RPRB COMPETENCY | 20/12/2017 | 19/12/2020 |

## ADDITIONAL MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FRAUD AWARENESS | | |
| MAPA | | |
| EQUALITY | 13/03/2014 | 12/03/2017 |
| RECRUITMENT SELECTION | | |
| SICKNESS ABSENTEEISM | | |
| HYPONATRAEMIA | | |
| ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW | | |
| | | |
| Complaints / Incidents | 08/10/2013 | |
| Coroners Cases | | |

| Module | Date |
|---|---|
| NEWS | |
| OEWS | |
| PEWS | |
| CONSENT | 06/07/2010 |
| BLOOD CULTURE | |
| PERIPHERAL LINE | |
| USE OF ANTICOAGs | |
| NG TUBE | |
| ACTIONS FOLLOWING DEATH | |
| PM CONSENT | |

| Module | Date |
|---|---|
| PRESCRIBING | |
| CLINICAL TRIALS | |
| VTE | |
| SAFE SEDATION | |
| GASTRO ENDOSCOPY | |
| CHEST DRAIN | |
| BLOOD GAS | |
| APPRAISER | |
| APPRAISSEE | 08/03/2016 |
| NEGLIGENCE | |

## COURSES FOR RECOGNISED TRAINERS

| Activity | Activity date | Activity date expires |
|---|---|---|
| | | |
| | | |
| | | |

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust
*Quality Care - for you, with you*

# Paying Patients Declaration 2015

*Any professional service that a Consultant carries out for a third party and which are not part of their contractual services must be declared to the Trust. Therefore in order to comply with financial governance controls all consultants as part of their contractual obligations must inform the Trust of any paying patient work that they are undertaking.*

| | Please tick to accept |
|---|---|
| I do not treat / intend to treat paying patients either inside or outside the Trust | ☐ |
| I am treating / intend to treat paying patients:- | |
| Inside the Trust | ☐ |
| Outside the Trust | ☑ |
| Inside and Outside the Trust | ☐ |
| I confirm that I have read and understood the Trust Guide to Paying Patients & accept the responsibilities outlined in the Guide – click here | ☑ |
| I understand that any work carried out by medical secretaries to assist my paying patient work must be completed outside NHS working time | ☑ |
| I understand that any paying patient work must be included in my job plan | ☑ |
| I agree to submit a quarterly declaration and payment to the Paying Patients Team for the use of Trust facilities for outpatient / medico-legal work – click here for forms | ☐ |

Consultant Name (PRINT): Personal Information redacted by the USI

GMC Number: Personal Information redacted by the USI

Signed: Personal Information redacted by the USI

Date: 27 November 2015

Please return this declaration via email to katie.shields Personal Information redacted by the USI or via internal mail to Katie Shields, Medical Directorate, Clanrye House, Daisy Hill Hospital.

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

General Medical Council

18/12/2016

A. O'Brien Esq., FRCS
Personal Information redacted by the USI

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201

**Certificate of proof of entry on the register**

Name: O'Brien, Aidan

GMC reference number: Personal Information redacted by the USI

Gender: Man

Primary medical qualification: MB BCh 1978 Queens University of Belfast

**Registration and licensing history:**

| Status | From | To |
|---|---|---|
| Full with specialist registration with a licence to practise | 07/08/2013 | |
| Full registration with a licence to practise | 16/11/2009 | 07/08/2013 |
| Full registration | 27/02/1980 | 16/11/2009 |
| Provisional registration | 28/12/1978 | 27/02/1980 |

**Specialist Register entry:**

| Specialty | Sub-specialty | Date of entry |
|---|---|---|
| Urology | None | 07/08/2013 |

Annual retention fee due date: 27/02/2017



Working with doctors Working for patients

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## Certificate of proof of entry on the register

Name: O'Brien, Aidan

GMC reference number: Personal Information redacted by the USI

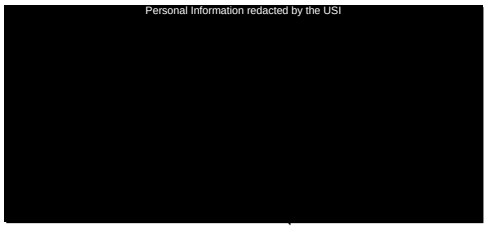
## This certificate

All doctors who want to practise medicine in the UK must hold both registration and a licence to practise.

If the doctor's current status includes a reference to APS, this means their practice in the UK is subject to the requirements of our approved practice settings (APS) scheme. You can find more information about APS at www.gmc-uk.org/aps/.

This certificate does not guarantee that this doctor's status on the register has not changed. You can check this doctor's status on the register, and find up to date details of their eligibility to practise medicine in the UK, at www.gmc-uk.org/lrmp or by calling us.

For information on what the details of this certificate mean, go to www.gmc-uk.org/certificates/.




Charlie Massey
Registrar



The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

General Medical Council

16/02/2017

Your GMC reference number: Personal Information redacted by the USI

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201

A. O'Brien Esq., FRCS
Personal Information redacted by the USI

Dear Mr O'Brien

**Annual retention fee confirmation for registration year starting 27/02/2017**

I confirm that you have paid the appropriate fees required by the General Medical Council Registration Fees Regulations, either in full or by way of a Direct Debit arrangement.

This confirmation is not proof that you are currently registered, nor proof of identity. You or your employer can check your current status on our online register, the List of Registered Medical Practitioners, on our website. You can also call us on 0161 923 6602 (+44 161 923 6602 from outside the UK) with your GMC reference number and select option one.

This is not a receipt. Receipts for payments made in the last six years can be printed from your GMC online account.

Yours sincerely

Personal Information redacted by the USI

**Steven Downs CPFA**
**Assistant Director - Finance and Procurement**
**Resources Directorate**



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Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

Skip to content

Working with doctors Working for patients

**Logged in as Mr O'Brien GMC Ref:** [redacted]

My Details

My Account

My Registration

**My Revalidation**

My Appointments

My Surveys

My Tests

Contact Us

Good Practice

# Revalidation details

The date you last revalidated was 28/04/2014.

All fully registered doctors with a licence to practise need to revalidate to show more about revalidation.

Please check the designated body information below. If you're happy it's corre

If it's not correct please click 'Change designated body'.

If you don't know your designated body you can use our online tool to help yo

If you are sure you don't have a designated body please click 'I don't have a c

| | |
|---|---|
| **Designated body** | Southern Health and Social Care Trus |
| **Responsible officer** | Robert Wright |
| **Designated body email address** | [redacted] |
| **Next submission date** | 27/04/2019 |
| **Designated body last updated by** | General Medical Council |
| **Designated body last updated on** | 16/04/2012 |

Confirm designated body  Change designated body  I d

Browsealoud

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Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

CHKS
insight for better healthcare

# CHKS Consultant Level Indicator Programme

## The Southern Trust

## January 2016 to December 2016

Personal Information redacted by the USI : Mr Aidan O'Brien

## Urology

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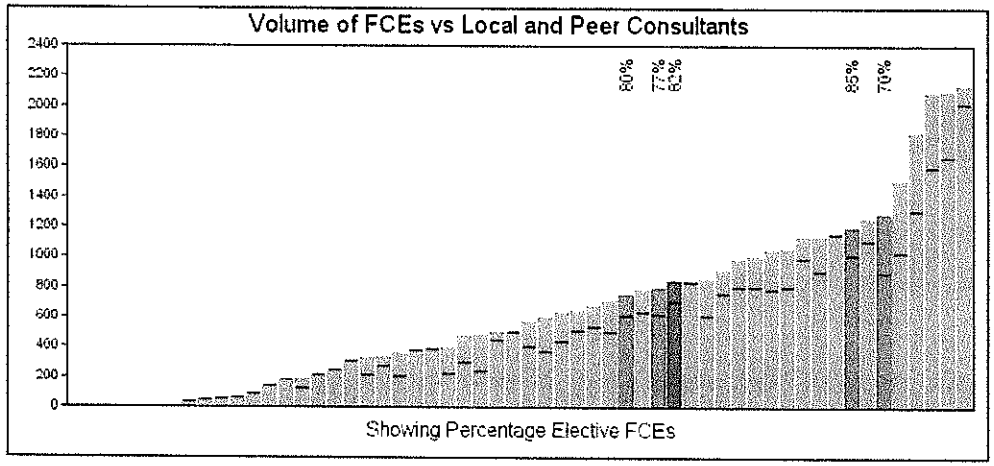
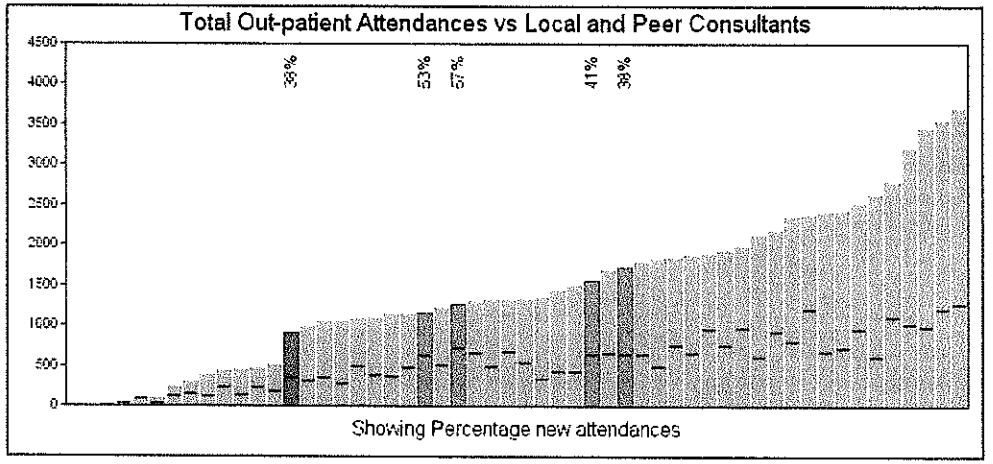
CHKS
Insight for better healthcare

# The Southern Trust
# Personal Information redacted by the USI : Mr Aidan O'Brien - Urology
# January 2016 to December 2016




| Workload Volumes | Consultant | | Local | |
|---|---|---|---|---|
| Total Number of FCEs | 849 | | | |
| Elective FCEs | 698 | 82.2% | 77.6% | 79.6% |
| In-Patients | 202 | 28.9% | 15.4% | 21.6% |
| Day Cases | 496 | 71.1% | 84.6% | 78.4% |
| Emergency FCEs | 121 | 14.3% | 19.9% | 19.7% |
| Other FCEs | 30 | 3.5% | 2.6% | 0.7% |
| * Regular Attendances | | | 6.7% | 2.4% |

* Regular Attendances are counted **only** in this report line

They are expressed as a percentage of Elective FCEs (above) + Regular Attendances

They are NOT aggregated into any other data line or chart

| In-Patient Details | Consultant | | Local | |
|---|---|---|---|---|
| FCEs - Male | 526 | 62.0% | 62.3% | 68.9% |
| FCEs - Female | 323 | 38.0 | 37.7 | 31.1 |
| | | | | |
| FCEs - Child (0-18) | 27 | 3.2% | 2.6% | 5.1% |
| FCEs - Adult (19-74) | 576 | 67.8% | 72.6% | 65.4% |
| FCEs - Elderly (75+) | 246 | 29.0% | 24.7% | 29.5% |

| Outpatient workload | Consultant | | Local | |
|---|---|---|---|---|
| Total Attendances | 920 | | 1440 | 1481 |
| New Attendances | 347 | 37.7% | 46.0% | 36.0% |
| Follow-up Attendances | 573 | 62.3% | 54.0% | 64.0% |
| Attendances with Procedure | 89 | 9.7% | 2.4% | 32.7% |

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Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

CHKS
insight for better healthcare

# The Southern Trust
# Personal Information redacted by the USI : Mr Aidan O'Brien - Urology
# January 2016 to December 2016

Consultant Total FCEs : 849 31,658 : Peer FCEs

## Performance Indicators

| | Consultant | | Local | Peer |
|---|---|---|---|---|
| FCE Inpatient ALoS (DC trimmed) | | 4.0 | 3.3 | 2.1 |
| Average Length of Stay (Zero trimmed) | | 4.7 | 3.8 | 3.0 |
| Elective | | 3.7 | 2.6 | 2.4 |
| Non-Elective | | 5.8 | 4.4 | 3.7 |
| Risk Adjusted Length of Stay * | | 104.3 | 117.9 | 85.1 |
| Day Case Rate | 496 | 71.1% | 84.6% | 78.4% |
| Day Case Overstays | 27 | 5.2% | 5.2% | 5.9% |
| Average Elective Pre-Operative LoS | | 0.2 | 0.1 | 0.1 |
| Elective IP Spells with no Procedure | 3 | 3.0 | 0.6 | 0.5 |
| Elective Inpatient spells - procedure not carried out | | | 1.6% | 0.6% |
| Patient Cause | | | | |
| Other Reason | | | 1.6% | 0.6% |

## High Volume Procedures

| | Actual Day Cases | | | | | | Day Case Overstays | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | | | Rate of All Elective FCEs | | | Number | | | Average LoS | | |
| Day Case Procedures | Consultant | Local | Peer | Consultant | Local | Peer | Consultant | Local | Peer | Consultant | Local | Peer |
| M45 - Diagnostic endoscopic examination of bladder | 186 | 278.0 | 163.8 | 95.9% | 98.2% | 96.5% | 2 | 2.0 | 5.2 | 2.5 | 1.5 | 1.4 |
| M49 - Other operations on bladder | 146 | 72.0 | 108.8 | 99.3% | 99.7% | 99.5% | 1 | | 1.3 | 1.0 | | 1.4 |
| M43 - Endoscopic operations to increase capacity of bladder | 36 | 11.0 | 13.8 | 87.8% | 91.7% | 91.9% | 1 | 1.0 | 2.5 | 1.0 | 1.0 | 1.5 |
| N30 - Operations on prepuce | 8 | 18.8 | 24.2 | 61.5% | 91.5% | 92.8% | | 3.0 | 2.0 | | 1.0 | 1.3 |
| N11 - Operations on hydrocele sac | 7 | 5.0 | 5.8 | 87.5% | 88.2% | 88.6% | 1 | 1.0 | 1.7 | 2.0 | 1.0 | 1.1 |
| M29 - Other therapeutic endoscopic operations on ureter | 6 | 15.7 | 15.0 | 37.5% | 71.2% | 66.5% | 2 | 2.3 | 4.8 | 2.0 | 1.0 | 1.5 |
| U26 - Diagnostic testing of genitourinary system | 4 | 1.0 | 34.0 | 100.0% | 100.0% | 100.0% | | | | | | |
| M47 - Urethral catheterisation of bladder | 3 | 3.0 | 25.3 | 100.0% | 80.0% | 96.4% | | | 1.7 | | | 1.8 |
| N06 - Other excision of testis | 3 | 1.0 | 2.7 | 75.0% | 33.3% | 69.9% | | | 1.4 | | | 1.2 |
| M16 - Other operations on kidney | 2 | 8.0 | 0.4 | 25.0% | 69.6% | 16.2% | 1 | 1.0 | 1.0 | 2.0 | 1.0 | 3.0 |

| | Number | | | Pre-Op Average LoS | | | IP Average LoS | | |
|---|---|---|---|---|---|---|---|---|---|
| In-Patient Procedures | Consultant | Local | Peer | Consultant | Local | Peer | Consultant | Local | Peer |
| M65 - Endoscopic resection of outlet of male bladder | 36 | 11.0 | 21.9 | 0.8 | 0.1 | 0.1 | 4.3 | 3.0 | 2.6 |
| M27 - Therapeutic ureteroscopic operations on ureter | 20 | 15.0 | 7.2 | 1.0 | 0.5 | 0.3 | 2.5 | 3.0 | 1.5 |
| M29 - Other therapeutic endoscopic operations on ureter | 20 | 12.0 | 10.2 | 0.7 | 0.5 | 0.5 | 3.8 | 3.8 | 2.3 |
| U21 - Diagnostic imaging procedures | 18 | 24.8 | 12.3 | 2.0 | 6.9 | 3.0 | 6.5 | 3.4 | 2.3 |
| M42 - Endoscopic extirpation of lesion of bladder | 18 | 15.8 | 22.5 | 1.4 | 0.7 | 0.2 | 6.2 | 3.0 | 1.9 |
| M45 - Diagnostic endoscopic examination of bladder | 12 | 9.2 | 6.1 | 0.0 | 0.0 | 0.4 | 2.8 | 2.4 | 1.2 |
| M16 - Other operations on kidney | 8 | 2.0 | 1.3 | 1.2 | 1.0 | 0.6 | 4.4 | 12.2 | 3.7 |
| M02 - Total excision of kidney | 6 | 3.2 | 7.2 | 0.2 | 0.0 | 0.3 | 10.5 | 4.5 | 4.4 |
| M76 - Therapeutic endoscopic operations on urethra | 6 | 3.2 | 3.4 | 0.0 | 0.0 | 0.2 | 0.8 | 0.8 | 1.2 |
| M79 - Other operations on urethra | 6 | 0.5 | 0.3 | 0.0 | 0.0 | 0.1 | 0.7 | 1.5 | 0.6 |

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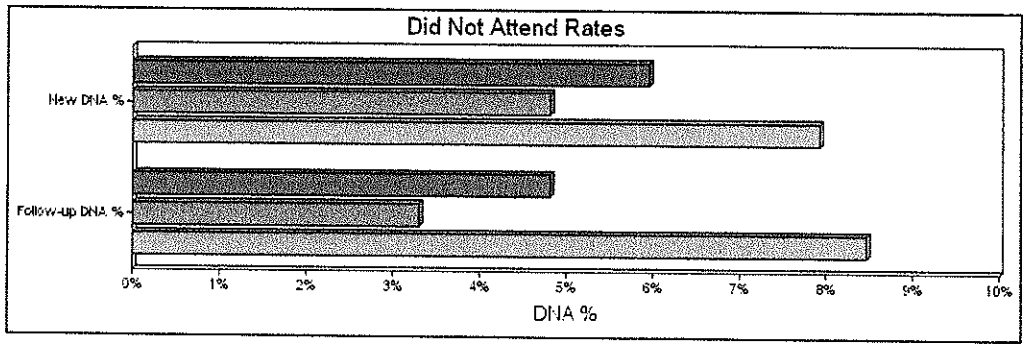
**The Southern Trust**
**Personal Information redacted by the USI : Mr Aidan O'Brien - Urology**
**January 2016 to December 2016**

| | Consultant | | Local Peer | | Selected Peer | |
|---|---|---|---|---|---|---|
| | Volume | Percentage / Rate | Average / Cons | Percentage / Rate | Average / Cons | Percentage / Rate |
| Total Attendances | 920 | | 1440 | | 1481 | |
| New Attendances | 347 | 37.7% | 663 | 46.0% | 533 | 36.0% |
| Referred by General Practitioner | 181 | 52.2% | 478 | 72.1% | 408 | 71.9% |
| With Procedures Recorded | 80 | 23.1% | 31 | 4.6% | 165 | 29.2% |
| Average Procedure per coded attendance | | 1.1 | | 1.0 | | 1.1 |
| Did Not Attend | 22 | 6.0% | 34 | 4.8% | 49 | 7.9% |
| Follow-Up Attendances | 573 | 62.3% | 777 | 54.0% | 949 | 64.0% |
| With Procedures Recorded | 9 | 1.6% | 4 | 0.5% | 330 | 34.7% |
| Average Procedure per coded attendance | | 1.1 | | 1.0 | | 1.1 |
| Did Not Attend | 29 | 4.8% | 26 | 3.3% | 88 | 8.5% |
| New : Follow-Up Ratio | 573 | 1 : 1.7 | 777 | 1 : 1.2 | 1010 | 1 : 1.8 |




| Top ten Procedures Reported (Volume) | Consultant | Local | Peer |
|---|---|---|---|
| M47 - Urethral catheterisation of bladder | 89 | 29 | 8 |
| M70 - Other operations on outlet of male bladder | 0 | 6 | 13 |
| M45 - Diagnostic endoscopic examination of bladder | 0 | 0 | 119 |
| U26 - Diagnostic testing of genitourinary system | 0 | 0 | 4 |
| X36 - Blood withdrawal | 0 | 0 | 1 |
| Q55 - Other examination of female genital tract | 0 | 0 | 1 |
| X38 - Subcutaneous injection | 0 | 0 | 1 |
| X62 - Assessment | | | 274 |
| U32 - Diagnostic blood tests | | | 92 |
| H62 - Other operations on bowel | | | 7 |

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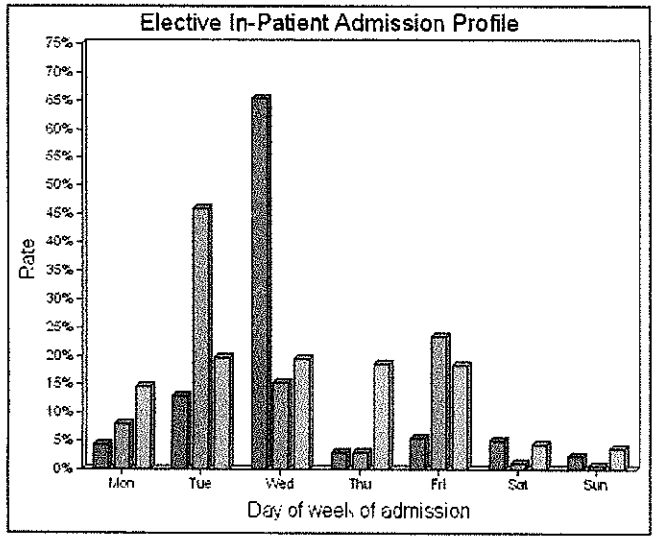
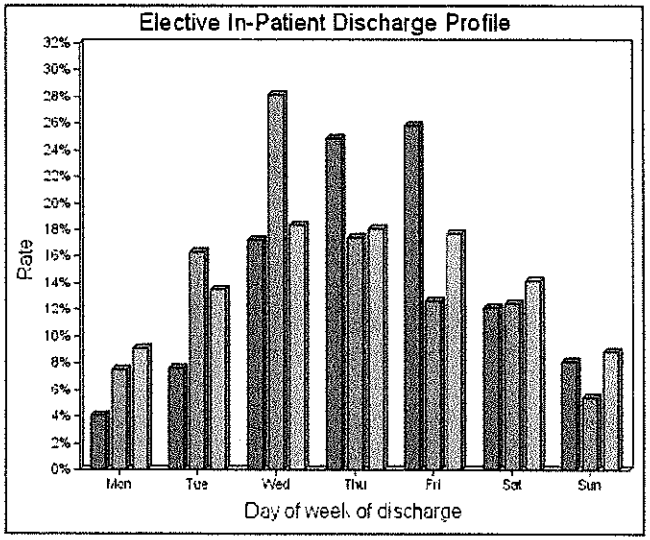
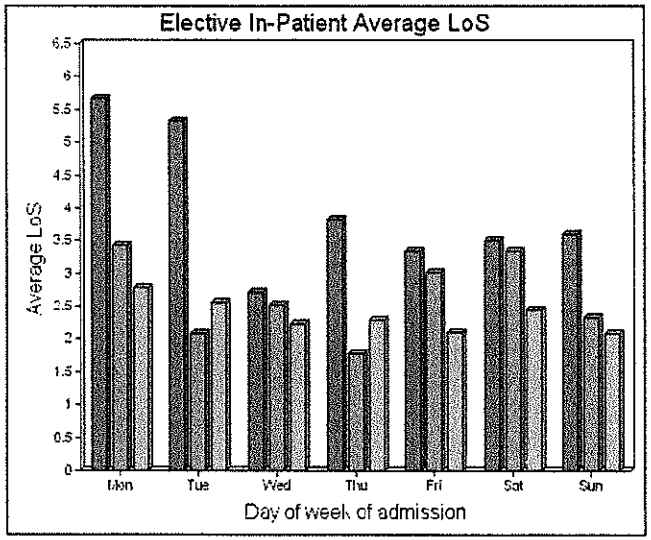
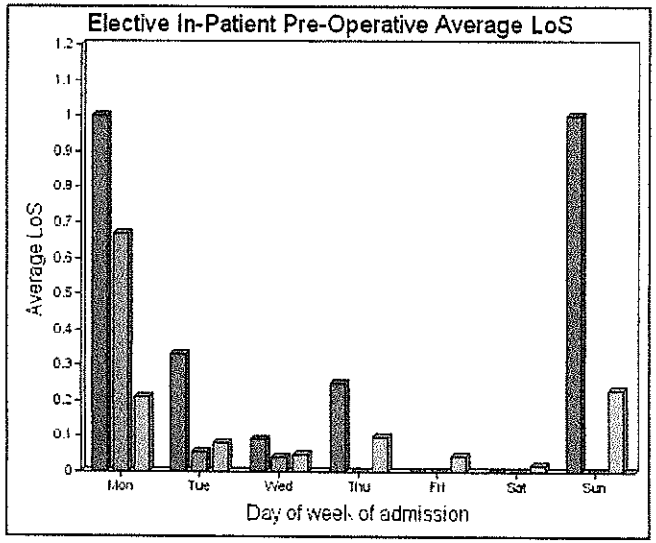
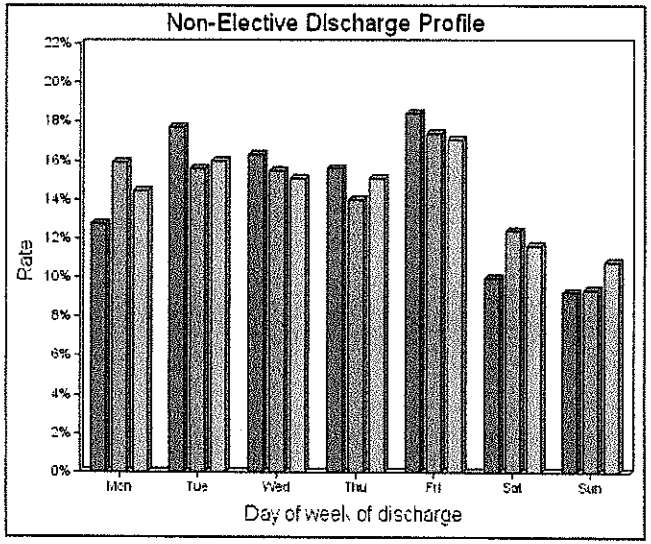
# The Southern Trust
# [redacted] : Mr Aidan O'Brien - Urology
# January 2016 to December 2016

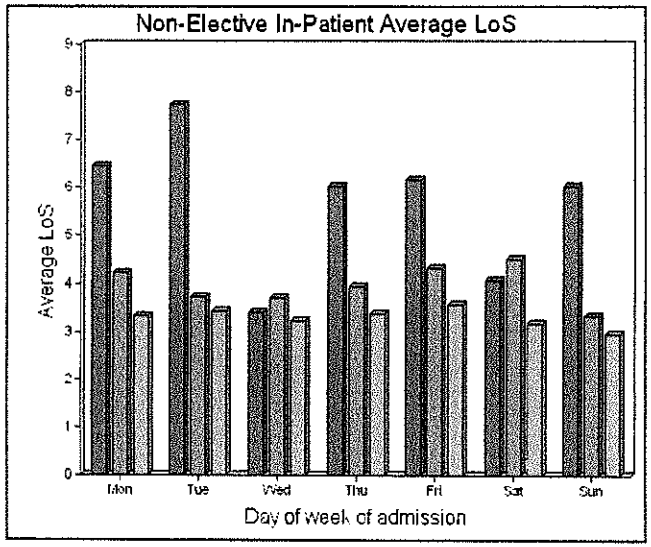
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# The Southern Trust
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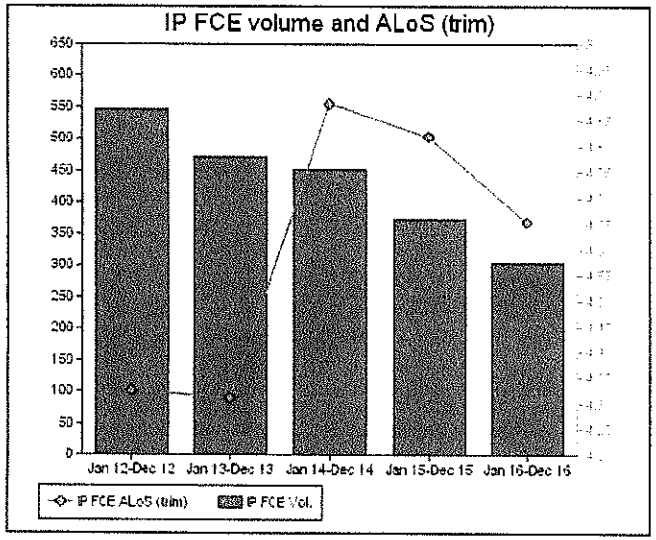
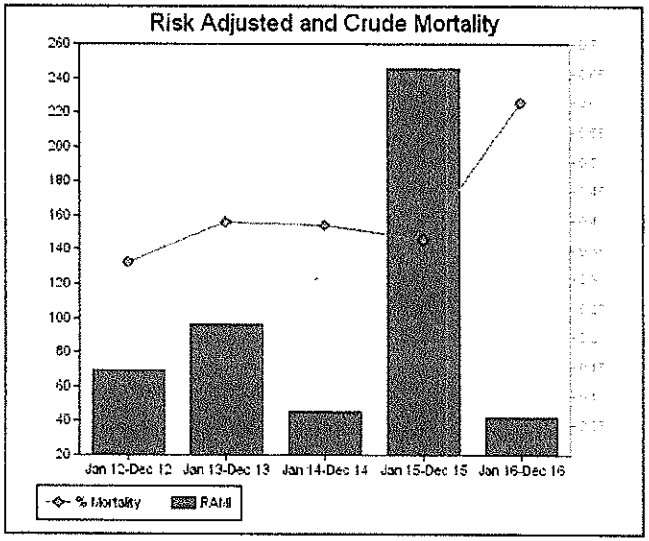
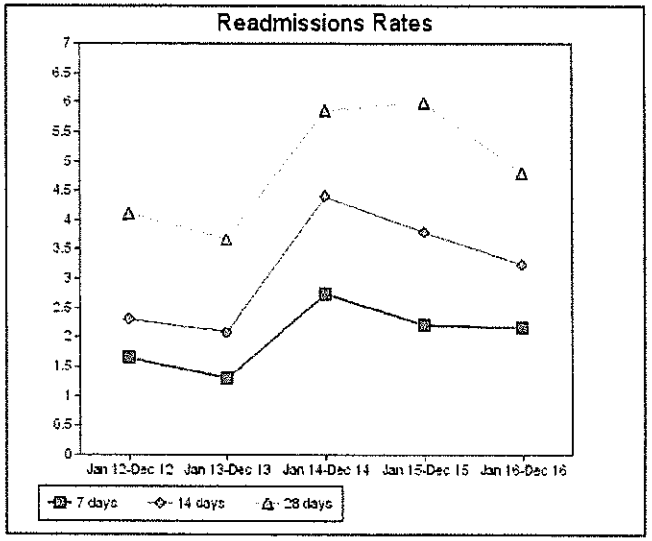
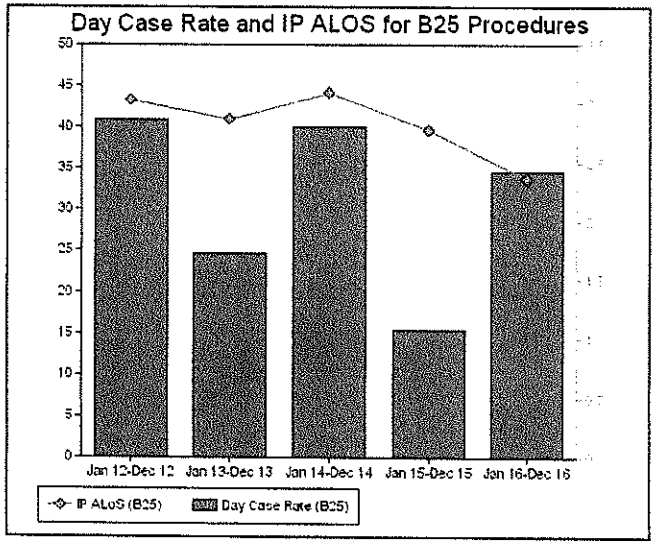
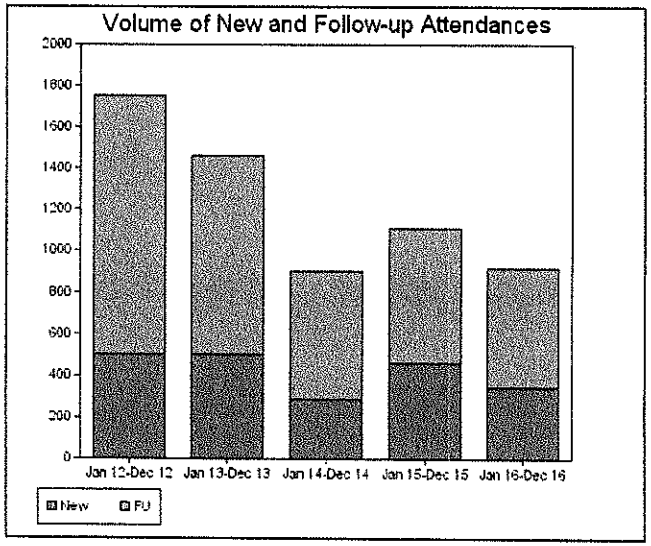
## January 2016 to December 2016

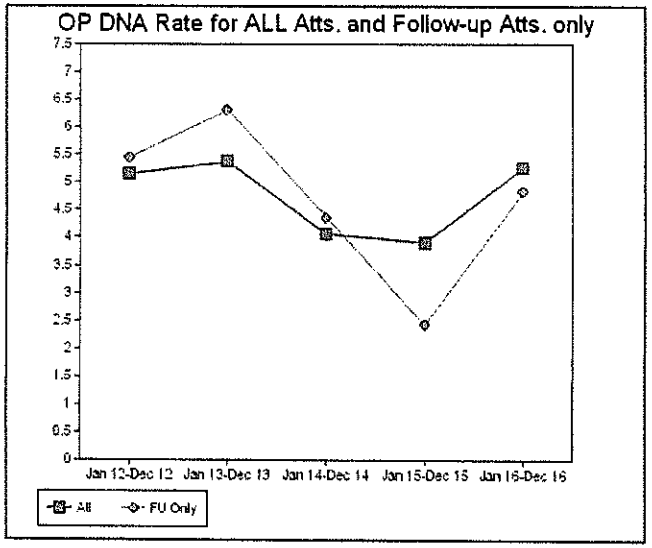
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## CHKS CLIP Programme :- Indicator definitions

## Report Indicator Definitions (Surgical)

## Workload Volumes

**Total FCEs**

Numerator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

**FCEs (incl. day cases) per inpatient DCC**

Numerator: Count of FCEs / 52 (weeks in year)
Denominator: Number of inpatient direct clinical care (DCC) sessions
Exclusions: Well babies, regular attenders and renal dialysis patients

**Elective FCEs**

Numerator: Count of elective FCEs
Denominator: Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

**Elective IP FCEs**

Numerator: Count of elective inpatient FCEs minus elective daycases
Denominator: Count of elective FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

**Day Case Rate**

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

**Emergency FCEs**

Numerator: Count of emergency FCEs
Denominator: Total FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

**Other FCEs**

Numerator: Count of OTHER (not elective or emergency) FCEs
Denominator: Total FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

**Regular attendances**

Numerator: Count of regular attenders
Denominator: Total elective FCEs including regular attenders
Exclusions: Well babies

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## Clinics in 2016 (excluding SWAH clinics)

2016 was a 30.5 week year [redacted]

| | | | |
|---|---|---|---|
| **Armagh:** | Job Plan: | One clinic per calendar month<br>7 clinics | |
| | Actual: | 4 clinics | |
| **Craigavon New Clinic:** | Job Plan: | One clinic per week<br>30.5 clinics | |
| | Actual: | 21 clinics | |
| **Craigavon Review Clinic:** | Job Plan: | One clinic per week<br>(when not in Armagh or SWAH)<br>20.5 clinics | |
| | Actual: | 12 clinics | |
| **Specialty Clinics:** | Job Plan: | One clinic per week<br>30.5 clinics | |
| | Actual: | Oncology:<br>Urodynamics<br>Urodyns & Oncology:<br>---<br>Total Spec. Clinics | 8 clinics<br>9 clinics<br>33 clinics<br>---<br>50 clinics |

| | |
|---|---|
| Total Job Planned Clinics: | 88.5 clinics |
| Actual Clinics: | 87 clinics |

| | |
|---|---|
| **Total additional clinics in 2016:** | **- 1.85 clinics** |
| **Total additional clinic session time in 2016:** | **- 7.4 hours** |
| **Mean additional administrative time per clinic:** | **1 hour** |
| **Total additional time allocated to clinics;** | **- 9.25 hours** |
| **Mean Additional time allocated to clinics per week:** | **- 0.3 hours** |

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# CLIP (Consultant Led Indicator Programme) Report structured reflective template

Requirement: One annually

| Name of doctor: Aidan O'Brien | GMC No: [redacted] |
|---|---|
| Date of report:<br>January 2016 to December 2016 | |

What issues can I identify from the report?

For several years, I have had doubts regarding the reliability and utility of the data contained within CLIP reports. On this occasion, I have had reason to have a detailed knowledge of all of the sessions of clinical activity conducted during the first ten months of 2016 ([redacted]). I conducted 83.25 elective inpatient operating sessions during that time, in contrast to the 58 sessions in my job plan. However, that additional operative work had only a minimal, negative effect on outpatient clinic activity (1.5 sessions). Moreover, the CLIP report takes no account of sick leave or other circumstances impacting upon performance.
The report has detailed that I performed 36 prostatic resections in 2016. I actually performed 46. I have written to CHKS seeking an explanation. I have not received a reply.

What actions will I undertake?

At best, none. I will be even more circumspect than before regarding the merit of CLIP reports, if there is any.

Final outcome after discussion at appraisal:
(Complete at appraisal)

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Competencies

# Mandatory Training Passport

Print as PDF

## CORE MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FIRE | 07/12/2015 | 06/12/2016 |
| INFECTION CONTROL | 08/10/2013 | 08/10/2015 |
| SAFEGUARDING | 29/04/2014 | 28/04/2017 |
| INFORMATION GOVERNANCE | 17/04/2014 | 16/04/2017 |
| H&S COSHH | 08/10/2013 | 07/10/2016 |
| BACKCARE | 13/03/2014 | 12/03/2017 |
| RPRB DESIST? | | |
| RPRB THEORY | 16/04/2014 | 16/10/2015 |
| RPRB COMPETENCY | 16/04/2014 | 15/04/2017 |

## ADDITIONAL MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FRAUD AWARENESS | | |
| MAPA | | |
| EQUALITY | 13/03/2014 | 12/03/2017 |
| RECRUITMENT SELECTION | | |
| SICKNESS ABSENTEEISM | | |
| HYPONATRAEMIA | | |
| ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW | | |
| Complaints / Incidents | 08/10/2013 | |

| Module | Date |
|---|---|
| NEWS | |
| OEWS | |
| PEWS | |
| CONSENT | 06/07/2010 |
| BLOOD CULTURE | |
| PERIPHERAL LINE | |
| USE OF ANTICOAGs | |
| NG TUBE | |
| ACTIONS FOLLOWING DEATH | |
| PM CONSENT | |

| Module | Date |
|---|---|
| PRESCRIBING | |
| CLINICAL TRIALS | |
| VTE | |
| SAFE SEDATION | |
| GASTRO ENDOSCOPY | |
| CHEST DRAIN | |
| BLOOD GAS | |
| APPRAISER | |
| APPRAISSEE | 23/01/2014 |
| NEGLIGENCE | |

## COURSES FOR RECOGNISED TRAINERS

| Activity | Activity date | Activity date expires |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

# Mandatory Training Passport

**AOB-22868**

Aidan O Brien Urology Core Record Effective for 2017

Print as PDF

## CORE MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FIRE | 07/12/2015 | 06/12/2016 |
| INFECTION CONTROL | 08/10/2013 | 08/10/2015 |
| SAFEGUARDING | 29/04/2014 | 28/04/2017 |
| INFORMATION GOVERNANCE | 17/04/2014 | 16/04/2017 |
| H&S COSHH | 08/10/2013 | 07/10/2016 |
| BACKCARE | 13/03/2014 | 12/03/2017 |
| RPRB DESIST? | | |
| RPRB THEORY | 15/12/2015 | 14/12/2018 |
| RPRB COMPETENCY | 16/04/2014 | 15/04/2017 |

## ADDITIONAL MODULES

| Module | Date | Date Renewal |
|---|---|---|
| FRAUD AWARENESS | | |
| MAPA | | |
| EQUALITY | 13/03/2014 | 12/03/2017 |
| RECRUITMENT SELECTION | | |
| SICKNESS ABSENTEEISM | | |
| HYPONATRAEMIA | | |
| ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW | | |
| | | |
| Complaints / Incidents | 08/10/2013 | |
| Coroners Cases | | |

| Module | Date |
|---|---|
| NEWS | |
| OEWS | |
| PEWS | |
| CONSENT | 06/07/2010 |
| BLOOD CULTURE | |
| PERIPHERAL LINE | |
| USE OF ANTICOAGs | |
| NG TUBE | |
| ACTIONS FOLLOWING DEATH | |
| PM CONSENT | |

| Module | Date |
|---|---|
| PRESCRIBING | |
| CLINICAL TRIALS | |
| VTE | |
| SAFE SEDATION | |
| GASTRO ENDOSCOPY | |
| CHEST DRAIN | |
| BLOOD GAS | |
| APPRAISER | |
| APPRAISSEE | 08/03/2016 |
| NEGLIGENCE | |

## COURSES FOR RECOGNISED TRAINERS

| Activity | Activity date | Activity date expires |
|---|---|---|
| | | |
| | | |
| | | |

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## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**PERSONAL DEVELOPMENT PLAN for the year ahead**

| Development needs | Actions agreed | Target dates |
|---|---|---|
| To address in a durable and effective manner my long inpatient waiting list, and in so doing, to reduce inequity in waiting lists. | These are Trust issues to be discussed and agreed. | 2017 |
| To address long waiting list for urological cancer reviews. | | 2017 |
| To reduce the numbers of new patient consultations. | | 2017 |
| Attend Course – Urology | Enjoy Irish Society Meeting. | 2016. |
| | | |
| | | |
| | | |
| | | |



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## Personal Development Plan structured reflective template
Requirement: annual

| |
|---|
| Name of doctor: Aidan O'Brien |
| Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year:<br><br>During 2016, I focussed on the areas which I believed were most clinically pressing, performing 25 additional, inpatient operating sessions, and 20 additional oncology review sessions, in the ten months available to me. I have no doubt that doing so significantly reduced the poor clinical outcomes and suffering of significant numbers of patients. I also have no doubt that doing so contributed to the issues since subject to formal investigation. My appraiser recorded that these were Trust issues to be discussed and agreed in 2017. They have yet to be so!<br><br>Date of reflection: 30 November 2017 |
| Final outcome after discussion at appraisal:<br>(To complete at appraisal considering how your approach will improve patient care) |

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# Record of Attendance

# Morbidity and Mortality Meetings 2016

Craigavon Area Hospital

UROLOGY

## MR AIDAN O'BRIEN

4 out of 8 = 50% meetings attended

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.

MM Certificate 2016

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Incidents
Consultant Appraisal 1 January 2016 to 31 December 2016
Mr Aidan O'Brien

| ID | Record name | Incident date | Description | Action taken |
|---|---|---|---|---|
| [redacted] | Personal Information redacted by the USI | 21/10/2016 | Male child scheduled for circumcision on emergency list. Not consented as consultant working alone, no reg/sho cover. | Discussed with Sr Johnston,agreed to child been consented in department due to above circumstances & to minimize distress to child. |

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

Southern Health
and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

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

1. **Untriaged outpatient referral letters**

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

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

Total in Review backlog = 679

| | |
|---|---|
| 2013 | 41 |
| 2014 | 293 |
| 2015 | 276 |
| 2016 | 69 |

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

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

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

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

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**APPENDIX 1:**

Southern Health
and Social Care Trust

10 April 2012.

Dear Mr. O'Brien,

Re: Clinical Lead for the Urology Multidisciplinary Team

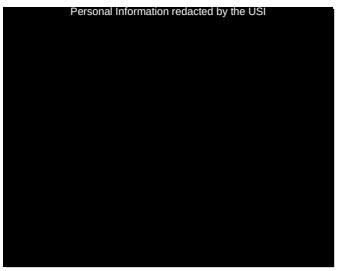
I understand that the Urology Cancer Multidisciplinary Team have nominated you as the Lead Clinician for the service.

I would like to confirm your position as Clinical Lead for the Urology Cancer Service from the 1st April 2012. This term of office will be for an initial 3 years, after which time it will be reviewed.

The role and responsibilities for the Lead Clinician are detailed in the Operational Policy for the service.

I would like to welcome you to the wider Cancer team and thank you for your agreement to act as the Clinical Lead.

Yours sincerely,




Dr. Rory Convery,
Clinical Director of Cancer Services,
Southern Health and Social Care Trust.

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

## Urology MDT Business Meetings 2016

## Objectives

The purpose of the Business Meetings of 2016 will be to review the progress of the Urology Multidisciplinary Team in its functionality and efficacy in meeting the criteria established and agreed by the National Cancer Plan, to address and resolve inadequacies and deficiencies, and to collate all required data (MDM attendances, quoracy, compliance with cancer timelines etc.,) in preparation for the provision and uploading of the required annual report in September of each year.

Business Meetings will be held at 12.30 pm on each of the following dates:

- Thursday 10 March 2016
- Thursday 19 may 2016
- Thursday 02 June 2016
- Thursday 01 September 2016

It is hoped that all MDT members will be able to attend on these dates,

Aidan O'Brien

Lead Clinician of MDT

28 February 2016.

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

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# Other roles structured reflective template

| |
|---|
| Name of doctor: Aidan O'Brien GMC No: [redacted] |
| Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role:<br><br>As Lead Clinician of Urology MDT, I have no doubt that I have contributed significantly to the improved management of urological cancers in the Southern Trust. In particular, I ensured continued 100% compliance with the 31 day timeline for new cancer referrals. |
| They also brought the following drawbacks to my main clinical role:<br><br>The role required and consumed considerable time, further exacerbated by the failure and refusal of clinicians to provide clinical summaries on each patient for discussion at MDM |
| I could consider the following actions, to maximise the benefits and minimise the drawbacks:<br><br>I stepped down from the role in December 2016<br><br>Date of reflection: 30 November 2017 |
| Final outcome after discussion at appraisal:<br>(Complete at appraisal considering how your approach will improve patient care) |

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## Significant event audit (SEA) structured reflective template

Requirement: one annually

**Name of doctor:** Aidan O'Brien **GMC No:** [redacted]

SEA Title:

Delayed Diagnosis of Renal Cell Carcinoma

Date of incident:

06 January 2016

Description of events:

A 59 year old lady had sigmoid colonic carcinoma managed by sigmoid colectomy and adjuvant chemotherapy in 2010. On CT scanning in 2010, she was reported to have a 'simple renal cyst particular in right. No solid renal mass.' There were in fact three right renal cysts considered at that time to be simple. On retrospective review of the images of the third annual CT scan in 2012, it was evident that some regional enhancement of one of the three cysts had developed. However, the report referred only to simple 'cyst present right kidney'. The patient then had right breast carcinoma diagnosed and managed by surgery, radiotherapy and hormonal therapy in 2013.

When CT scanning was requested by her GI surgeon and repeated in July 2014, it was reported that multiple, bilateral simple renal cysts were present, and that one of the right renal cysts 'demonstrated subtle layering with high density in its medial aspect which was probably present previously'. Ultrasound scanning was recommended. The GI surgeon wrote to the patient to reassure her of the benign nature of the cyst, while requesting the ultrasound scan which was performed later in July 2014 when it was reported this cyst contained 'echogenic, well-defined material posteriorly, possibly solid'. MRI scanning was recommended and performed in September 2014. The report did not include any reference to the cyst of concern, it only confirming that the largest right renal cyst was definitely simple.

The patient's oncologist also requested a CT scan in September 2014 to investigate recent right chest wall pain. This CT scan was performed in October 2014 and reported in November 2014, detailing the presence of both a large simple cyst and a smaller complex cyst containing solid and cystic components. The oncologist wrote to the patient in November 2014 to reassure her that the CT scan had reported no worrying abnormality.

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The patient's GP referred her to Urology in October 2014 on foot of the report of the MRI scan, relating that she had a history of bowel and breast cancer, had right renal angle pain and had been found to have a large right renal cyst, requesting assessment and advice. The referral was delivered to me for triage. As I did not have time to triage the referral, and would have retained its referral status as routine if I had had the time to do so, she did not have a urological outpatient consultation until 06 January 2016 when the potential significance of the smaller complex cystic lesion was appreciated.

On restaging by further CT scanning in January 2016, the complex cystic lesion remained unchanged, she was found to have partially healed fractures of her right sixth and seventh ribs (the cause of her pain), and was found to have left axillary lymphadenopathy. Biopsy confirmed metastatic breast carcinoma managed by lymphadenectomy, systemic chemotherapy and radiotherapy. The complex, right renal cystic lesion was resected in October 2016. It proved to be a papillary renal cell carcinoma. She has remained free of evidence of recurrence of all three carcinomata since.

The case became the subject of a SAI, though I am uncertain of the date of its initiation. I was not advised of the existence of any SAI until December 2016. I was provided with a draft report in January 2017. I was invited to return any comments (enclosed). The Root Cause Analysis was signed off in March 2017 (enclosed).

What went well?

The one feature of this case which went well was the decision of the urologist who met the patient when she attended on 06 January 2016 to arrange a CT scan of her chest, abdomen and pelvis, and which led to the diagnosis of metastatic breast carcinoma, and its management.

What could have been done better?

The change in the index, complex, right renal lesion was evident on CT scanning in December 2012, and could have been appreciated by the reporting radiologist. This change was reported on CT scanning in June 2014 and was reported to have probably been present previously. If it had been appreciated and reported in January 2013, its assessment and management could have proceeded then.

The potentially significant features of the lesion on CT and ultrasound scanning in 2014 could have been brought to the attention of the urological service by reporting radiologists, informally or via MDM. This did not occur.

Even though the patient's clinicians were advised in 2014 to request further imaging to further assess the complexity of the renal lesion, none considered referral of the patient to the urological service.

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Instead, the report of the definitive MRI scan inexplicably included no reference to the right renal lesion of concern, even though the scan was reported by the radiologist who had advised that MRI scanning be performed to further assess the lesion. Instead, the report described the entirely benign features of the larger, simple, right renal cyst. As a consequence, her GP referred her routinely for assessment of the possibility that the large, simple cyst was the cause of her pain.

The letter of referral was delivered to me on Thursday 30 October 2014. In addition to providing management of all urological inpatients and acute referrals from Daisy Hill and South West Acute Hospitals, I had spent several hours previewing all cases to be discussed at MDM which I chaired on that date, as well as reviewing ten cancer cases on 31 October 2014. I had advised that I had found it impossible to triage all referrals as well.

This routine referral could only have been upgraded to Red Flag status as a consequence of a review of all the previous radiological reports on NIECR, as a minimum, if not a review of imaging on NIPACS. Such a review would require a minimum of 10 – 15 minutes for each referral, some additional 20 hours for the approximate 120 referrals received each week at that time. No predictable time was allocated in job plans to triage.

The Trust stated in January 2017 that it had an agreed Policy and Procedure on Triage. The Trust confirmed in October 2018 that it did not have one. In January 2017, I requested that Management discuss with clinicians to agree such a Policy, and particularly in the context of the waiting times for urgent and routine outpatient consultations, now 97 and 149 weeks, respectively. It has not yet done so. As a consequence, consultant urologists do not know what kind of triage is expected by the Trust, or when it should be done, so as not to compromise patient care or clinical outcomes.

What changes have been agreed?
Personally:

As I have continued to find it impossible to triage all referrals (approx. 180) received while urologist of the week, I take a day of annual leave after completion of my urologist of the week, and I spend that day and the following weekend to complete triage, in my own time.

For the team:

All consultants will receive an allocation of eight hours in their new Job Plans as predictable time for triage. The allocation would only be adequate if triage is conducted entirely on the information provided in the referral, and without any regard to waiting times.

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Final outcome after discussion at appraisal:
(Complete at appraisal considering how your outcome will improve patient care)

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# Formal Investigation & Exclusion

In my last appraisal for the year 2016, I included the letter of the 23 March 2016 that had been given to me by Mr. Eamon Mackle, Associate Medical Director, and accompanied by Mrs. Martina Corrigan, Head of Service for ENT and Urology, who represented Mrs. Heather Trouton, Assistant Director, detailing their concerns regarding referrals which had not been triaged, outpatient review backlog, an allegation that there had been no record of consultations in patients' notes or on Patient Centre, and my having patients' notes at home. The letter requested that I respond with a commitment and immediately plan to address the concerns. I immediately asked what I should do. I was answered with a shrug of the shoulders.

I left that brief meeting wholly despondent, knowing that I would receive no support or assistance in addressing the concerns. I still remained Lead Clinician of Urology MDT, having responsibility for endeavouring to ensure that urological cancer diagnostic and therapeutic services were delivered to patients within the required timelines. In addition, I was daily conscious of the morbidity suffered by so many patients on our waiting lists, morbidity which was often acute and life threatening, requiring acute readmission to hospital with urosepsis as a consequence of the delay in elective admission for definitive surgical management. For that reason, I used every available operating session, undertaking 22 additional operating sessions during 2016 to endeavour to mitigate the risk to patients. I similarly conducted an additional 10 oncology review clinics for similar reasons.

During all of this time, I [redacted] in order to provide continued support to one of my consultant colleagues while he was urologist of the week. When he advised me that he had taken up an appointment in England, commencing in November 2016, I [redacted] I had also received the agreement of Mrs. Corrigan, Head of Service, to use my time of recovery at home to process and have patients' charts returned from my home. I did so by contacting all patients by telephone to update their clinical status, dictating letters to GPs and to the patients themselves. In doing so, I had scheduled all inpatient and day case operating for January 2017, and had my secretary schedule review appointments for the more clinically significant patients at clinics in January and February 2017. In doing so, I had processed two thirds of all the remaining patients.

I then received a call on 28 December 2016 to advise that the Medical Director wished to meet with me on Tuesday 03 January 2017. I advised that I would be unable to do so at the stipulated time at I would be operating. I offered to speak with him by telephone. However, I was advised that he required to meet me in person. I enquired whether he appreciated that I was still on [redacted] leave. I was advised that he did. I offered to meet with

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him on Friday 30 December 2016 instead. That offer was accepted. As I then wondered what the meeting could be about, I requested an agenda. On receipt of the agenda, and which included the advice that I could be accompanied for support, I became greatly concerned.

I attended the meeting, accompanied by my wife, on 30 December 2016 when I was advised that an Oversight Committee had decided that a formal investigation of my administrative practices be held, and that I was to be immediately excluded from the workplace for a period of time, and up to a maximum of four weeks. As I was subsequently to learn from the record of this Oversight Committee, and made available to me only in October 2018 after requests had been ignored since July 2017, this has been just one of the untruths perpetuated during the past two years, as the Oversight Committee had determined on 22 December 2016 that I should be formally excluded for the duration of a formal investigation, which took 18 months to complete, breaching the Trust's own guidelines in doing so.

The month of January 2017 was the most traumatic month for me in my lifetime. In pointing out that the Trust had breached its own Guidelines, a Case Conference was held on 26 January 2017 when it was determined that there was no need for continued exclusion, and that I could return to work, under the terms to be advised by Occupational Health. Whilst I was so pleased to be able to return to work, not least out of concern for patients, I was a difficult process.

Since then, any residuum of confidence which I had in the integrity of a number of senior personnel in the Trust has been completed demolished. Most importantly, any belief that I had in their claim that their conduct, actions and inactions had been guided by concern for the welfare of patients, has been completely eliminated.

This domain of Good Medical Practice has been one in which I have been widely acknowledged to excel in. Not a clinic ends without my having been thanked by patients and relatives for my explanation of their condition, their options of management and the manner in which it has been communicated. I do believe that I have always endeavoured to work collaboratively and respectfully with my colleagues whose support I have enjoyed throughout my career. I have had continuity of patient care a first priority, maintaining with them a partnership in their ongoing care, indefinitely. Most importantly, I have done so with honesty and transparency.

To then be subjected to an investigative process which has been lacking in honesty and transparency, and which has included fabrication, misinformation and prejudice, has been the most traumatic, disillusioning and demoralising experience of my 40 year career in medicine.

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## FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

**Review of last year's Personal Development Plan**

| Development needs | Actions agreed | Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved? |
|---|---|---|
| Resolution of the concerns raised in the letter of 23 March 2016 | To cooperate with the Investigation of the concerns raised | I participated fully in the Investigation. |
| Continued Professional Development | To attend a Urological Conference | I attended the Annual Meeting of the British Association of Urological Surgeons in Liverpool in June 2018. |
| | | |
| | | |
| | | |
| | | |
| | | |

CLICK HERE **for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click** here.



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## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| PERSONAL DEVELOPMENT PLAN for the year ahead | | |
|---|---|---|
| **Development needs** | **Actions agreed** | **Target dates** |
| To have a written expectation from the Trust of its expectations of me when urologist of the week | Memorandum of understanding of what is expected from the Trust. | Decemb. 2018 |
| To have an clear, written understanding of the expectation of the Trust of the type of triage to be conducted, and when it should be conducted. | Memorandum. + to adhere to Trust Policy | Decemb 2018 |
| Continued Professional Development | To attend EAU in Barcelona in March 2019 | Decemb 2018 |
| Use college template to record CPD | Use college Templ | |
| | | |
| | | |
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| PERSONAL DEVELOPMENT PLAN for the year ahead | | |
|---|---|---|
| **Development needs** | **Actions agreed** | **Target dates** |
| To continue to dictate letters following every outpatient consultation | Addressing letter of Concern | December 2017 |
| To continue to triage all referrals | Addressing letter of Concern | December 2017 |
| To discuss issues relating to a heavy Job plan. | Discuss with line manager. | July 2018 |
| To attend an international meeting on urology | Attend meeting - ? EAU. | December 2017 |
| | | |
| | | |
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| | | |
| | | |

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.



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to suggest that Mr. O'Brien wasn't clearly and accurately writing a note into the patient's record following the encounter. They are two different things, are they not?

A. Yes. They are two separate things but they are interlinked in a way. 14:21

101 Q. You, with respect, have suggested that the offence or the shortcoming is the latter when, in fact, it was a dictation issue that was front and central of the investigation. Do you accept that? 14:21

A. Yes, that's the terms of reference. That's correct.

102 Q. Looking then at your determination, you have set out the advice that you have received. Let's just deal with the misconduct issue. If we go over the page, page 910 for you. If we scroll down, thank you. You 14:21 decided that you don't consider an exclusion from work to be necessary. Let's deal with that, sorry, a restriction on practice. The top of the page.

You set out the purpose of the action plan. As you 14:22 were reflecting just before lunch, you considered that a fresh action plan was necessary; isn't that's right?

A. That's correct, yes. So as part of adding this into my determination, I was very clear in my mind what part would be necessary in terms of having a continuous and 14:22 ongoing assurance. The action plan would have a number of elements. The first element is how the action plan should be developed in consultation with NCAS, Mr. O'Brien, and the Trust coming together, putting

together an action business plan which is, in essence, a combination of, you know, minds and brain coming together forming this action plan which will be owned by the consultant as well, and the Trust in terms of monitoring. That was the first element. 14:23

But then the monitoring of that action plan was not necessarily an operational line manager's, but I wish to add that into -- the clinical and the line management structure to the monitoring support and 14:23 escalation. Then at the same time, I wanted to include an agreed job plan, an enhanced appraisal element into part of the action plan as well.

103 Q. In terms of the scope of the action plan, you've described a need, in this second paragraph at the top 14:24 of the page, for continuing assurance about Mr. O'Brien's administrative practice and management of his workload. Did you anticipate that this action plan, if it had been developed at this time, would have scrutinised any other aspects of his practice, whether 14:24 other administrative issues or even clinical issues, or did you think in the alternative that you would be repeating the same issues that were the subject of the existing action plan?

A. So my thinking of developing the action plan in 14:25 consultation with NCAS, and Mr. O'Brien as well, to expand the action plan more a little bit wider to include the administrative practice but which can lead to poor clinical performance or poor clinical outcomes.

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# TRUST BOARD COVER SHEET

| | | | |
|---|---|---|---|
| Meeting Date | January 2024 | | |
| Agenda item | Medical Director's Report<br>Medical Appraisal and Revalidation | | |
| Accountable Director | Dr Stephen Austin – Medical Director | | |
| Report Author | Name | Maggie Davison | |
| | Email Address | Personal Information redacted by the USI | |
| This paper sits within the Trust Board role of: **Accountability** | | | |
| This paper is presented for: **Assurance** | | | |
| Links to Trust Corporate Objectives | ☐ | Promoting Safe, High Quality Care | |
| | ☐ | Supporting people to live long, healthy active lives | |
| | √ | Improving our services | |
| | ☐ | Making best use of our resources | |
| | ☐ | Being a great place to work – supporting, developing and valuing our staff | |
| | ☐ | Working in partnership | |

| | |
|---|---|
| WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY | *This report cover sheet has been prepared by the Accountable Director.*<br><br>*Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.*<br><br>*It details how it impacts the people we serve.* |



Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

## 1. Detailed summary of paper contents:

This paper outlines the purpose of Medical Appraisal and Revalidation. It also provides assurance to Trust Board on the implementation of the Responsible Officer Regulations in relation to Medical Revalidation.

## 2. Areas of improvement/achievement:

- Professional Governance arrangements underpinning the Revalidation and Appraisal processes continue to be strengthened.
  - New process agreed to standardise supporting information in relation to Complaints/incidents/SAI's/Litigations. Implementation date Jan 2024
  - Monitoring and Audit process for Paying and Private Practice
  - PPI/Service User involvement in SHSCT Appraisal and Revalidation process
  - Impending monitoring and regulation of Physician Associates (PA) and Biomedical technicians
  - Identification, recording, monitoring and reporting of training requirements for medical staff
- International Medical Recruitment (IMR) – all Drs to date have been allocated an Appraiser to facilitate completion of their Appraisal Induction (introduction to whole Practice Appraisal) awareness presentation with narrative has been developed and shared via email along with FAQ.
- Formation of Revalidation Board (Spring 2024)

## 3. Areas of concern/risk/challenge:

- The workload impact of COVID-19 has affected a minority of doctors completing their appraisals during this period; the Divisional Medical Directors are engaging with these doctors to support them in the completion of their appraisal.
- Current Medical Appraisal Lead retiring in March 2024, at present we have no replacement following EOI advertisement

## 4. Impact: Indicate if this impacts with any of the following and how:

| | |
|---|---|
| Corporate Risk Register | |
| Board Assurance Framework | |
| Equality and Human Rights | |



Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

## Table of Contents





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# 1. Medical Appraisal

Defined as:

*"A positive process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practicing within a safe and effective framework".*

The aims and objectives of appraisal are to enable doctors and employers to:

- Review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- Optimise the use of skills and resources in seeking to achieve the delivery of service priorities
- Consider the doctor's contribution to the quality and improvement of services and priorities delivered locally
- Define personal and professional development needs and agree plans for these to be met
- Identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- Provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider HSC
- Contribute to the governance requirements of the organisation
- Allow the process of *"Medical Revalidation"* of the doctor's licence to practice

# 2. Medical Revalidation

The General Medical Council (GMC) implemented a system of revalidation for its registrants in 2012 which was subsequently improved following the Pearson Review in 2017. The change in medical regulation was designed to provide an assurance to patients and the public that doctors are keeping up to date and are fit to practise. All registrants wishing to practise medicine have been issued with a licence to practise from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer, will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship are practising to the standards defined by the GMC in Good Medical Practice (1).

(1) http://www.gmc-uk.org/guidance/good_medical_practice.asp

As noted above, one of the main thresholds that a doctor has to reach is to have successfully completed five annual appraisals over the previous 5 years.



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## 3. Current position of Appraisal activity

Current Medical Appraisal position **12th January 2024.**

| Appraisal Year | Doctors Requiring Appraisals | Appraisal Complete | | Appraisal in Progress | | Appraisal Not Complete | |
|---|---|---|---|---|---|---|---|
| 2018 | 296 | 296 | 100% | 0 | 0% | 0 | 0% |
| 2019 | 345 | 344 | 99.9% | 0 | 0% | 1 | 0.1% |
| 2020 | 419 | 418 | 99.8% | 0 | 0.0% | 1 | 0.2% |
| 2021 | 446 | 440 | 98.7% | 1 | 0.2% | 5 | 1.1% |
| 2022 | 449 | 384 | 85.5% | 6 | 1.3% | 59 | 13.2% |

The Trust has increased awareness of Medical Appraisal throughout the Trust via a letter from the Medical Director to all substantive staff detailing the Medical Appraisal requirements, together with sharing of the new Medical Engagement Procedure timetable in January 2023. In addition, awareness has also been increased via Appraiser network meetings, raising the profile at Divisional Medical Directors meetings and Appraisal and Revalidation Newsletters. The Trust considers that this has influenced the improved appraisal performance.

The table detailed below outlines the relative performance of the last two appraisal years. There is a greater compliance in completing 2022 appraisals within the recommended time frame for completion.

| Appraisal Year | Doctors Requiring Appraisals | Appraisal Completed (by end of Dec following the appraised year) | | Overall increase |
|---|---|---|---|---|
| 2021 | 446 | 337 | 75.6% | |
| 2022 | 449 | 384 | 85.5% | ↑ 9.9% |

For the period from June 2017 to January 2023, there have been 98 recommendation(s) to defer due to insufficient evidence for 82 doctors(s) in the period selected. There have been 2 recommendation(s) to defer due to ongoing local processes for 2 doctor(s) in the period selected. There have been 463 positive recommendations for revalidation.

## 4. Appraisal Training

The Medical Directorate Appraisal and Revalidation Team continue to deliver bespoke Appraiser refresher/new appraiser training programme for 2024. The training has been bench marked against NHS England Appraiser training (2). The training is delivered every quarter by the Trusts Responsible Officer and Senior Managers form the Medical Appraisal and Revalidation Team. Training dates for 2024 have been circulated. The Medical Appraisal presentation will include relevant information pertaining to PA's.



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The PPI/Service User for Appraisal and Revalidation attended the training in Nov 2023, feedback in terms of delivery and contents was excellent.

(2) NHS England Appraiser training and support

## 5. New Appraisal/Revalidation dashboard

The Medical appraisal and revalidation dashboard for all Divisional Medical Directors is live and emailed to DMD's on a monthly basis. Our Data Quality Officer has been instrumental in finalising the current version.

The current dashboard has the capacity to track the year on year appraisal rates for comparison and has quarterly breakdowns. Doctors due for future revalidation are highlighted on the summary which supports future planning of revalidation meetings.

The following details the contents of the dashboard:

- Completion rate of appraisal in pictorial and data format.
- Revalidation – number of deferrals/revalidations
- Populates annual revalidations
- Identifies Appraisers within Division and number of appraisals completed or to be completed (inclusion in Job plans)

## 6. Medical Appraisal Facilitation Programme

The programme commenced in July 2022 and runs in conjunction with the Appraiser refresher/new appraiser training programme. New Appraisers continue to be invited to participate in the programme.

Appraisers who complete the Appraisal Mentoring Programme will be receive a certificate of completion which can be used as evidence of medical leadership development.

## 7. Regional Appraisal Programme System (RASP 'Preparation drop in sessions'

Supplementary to the Medical Appraisal Trust in-house Appraisal programme, the Medical Revalidation Senior Manager continue to deliver 'RASP drop in sessions' across Trust acute and non-acute sites. The sessions are always positively received. Drop-in sessions incorporate a question-and-answer style session, helping doctors to reinforce their understanding of the importance of Medical Appraisal and Revalidation including details on what is expected in their supporting information and discussion. Dates for 2024 have been circulated and will be facilitated in both Acute and Non Acute, sessions are facilitated either face to face or via Teams.

The drop-in sessions aim to:

- Improve the understanding of the roles and responsibilities of Medical Appraisal and Revalidation, the services we provide and the people who work within it.



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- Enhance opportunities for doctors to speak to members of the revalidation team bout particular issues or queries relating to their appraisal and revalidation.
- Offer timely advice and support at the point of need especially around accessing the Regional Appraisal system programme (RASP).

The drop-in sessions are offered on a regular basis (bi monthly) and will be themed to maintain focus for particular areas of support or guidance. The themes that will be covered include:

- Navigating the system
- Supportive information/documents
- Reflective Practice

## 8. Appraiser Network Meeting

Supplementary to the Medical Appraisal Facilitation Programme is the ongoing delivery and facilitation quarterly Appraiser Network Meetings. The purpose of these meetings is to facilitate new and existing Medical Appraisers to openly discuss positives aspects of the Appraisers role and also discuss concerns, issues in a supportive environment helping to enhance problem solving skills, action planning and personal and professional knowledge and skills. These meetings are facilitated by the Senior Appraisal and Revalidation Manager with Medical representation. 2024 meetings have been circulated.

## 9. Paying and Private Patients

Paying and Private patient's policy was implemented in July 2023. There is a dedicated Paying and Private patient tile on SharePoint including the new Electronic Change of Status form.


## 10. Electronic Change of Status form (Private to NHS Status)

New form implemented from 14th August 2023 to date we have 262 recorded forms. Formal evaluation of the form will take place in March 2024.

## 11. International Medical Recruitment (IMR)

All new international Dr's to date have been allocated an Appraiser. Information relating to Medical Appraisal has been shared with all Drs along with a narrated presentation on how to complete the Appraisal Induction Document.



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What is Medical Appraisal.pdf

## 12. Medical Mentoring Scheme

Medical Mentoring documentation has been shared with IMR key personal to support IMR Supervisors

## 13. Medical Mentoring Scheme

The Trust Medical Appraisal and Revalidation policy is fully implemented and embedded in practice.

The policy is easily accessible via SharePoint Medical Appraisal

## 14. Medical Engagement Procedure

The Trust Medical Appraisal and Revalidation Engagement Procedure will be reviewed. The review aims to change the timeframes recorded in the three formal non engagement letters, time frames in all letters will be brought forward by 4 weeks to facilitate Appraisal compliance, monitoring and escalation.

The policy is easily accessible via SharePoint Medical Appraisal.

## 15. Identification, recording, monitoring and reporting of training requirements for Medical Staff

A new SOP is currently under review and will outline the process for identification, recording, monitoring and reporting of various levels of training requirements for all grades of Medical staff who hold who hold core and/or Trust Locum Bank only posts within the Trust. Levels of training include Corporate Mandatory, Profession Specific Mandatory, Professional Role Essential and Professional Role Best Practice training.

The SoP will not apply to External Agency staff.

## 16. PPI/Service User involvement

To support and strengthen governance and patient experience Personal and Public Involvement (PPI) has been part of health and social care policy in Northern Ireland since 2007 and became law two years later with the introduction of the Health and Social Care Reform Act (2009). Most statutory health and social care organisations must, under legislation, meet the requirements of PPI. Effectively this describes the concept of involving ordinary people and local communities in the planning, commissioning, delivery and evaluation of the health and social care services they receive.

PPI/Service user is well-established in areas such as the training and recruitment of doctors, monitoring Annual Review of Competency Progression processes, interviews for clinical training posts, health research, formal patient experience bodies, patient participation groups in GP surgeries, Healthwatch, plus individual patient contributions through surveys and feedback such as Friends and Family.



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Since 2014, Milton Keynes University Hospital Trust (MKUHT) has had PPI members on their Revalidation Committee. The Committee plays a key role in supporting the responsible officer in making recommendations and driving up the quality of appraisal. The committee consists of lead appraisers, staff from the responsible officer's office and a further lay member.

The SHSCT PPI/Service user play a full role in the business of the Committee: mainly quality assuring appraisal and revalidation, providing recommendations for Appraisal/Appraisee training and feedback to appraisers.

## 17. Trust Revalidation Board

The Trust will facilitate its first Medical Appraisal and Revalidation Board meeting in March 2024. The purpose of the Medical Appraisal and Revalidation Board is to provide assurance to the Trust Board on the quality and performance of Appraisal and Revalidation of non-training grade medical staff employed at Southern Trust.

The Board has been established to

1. To quality assurance appraisal and revalidation in SHSCT
2. To ensure that updated GMC Guidance is incorporated into SHSCT systems and policies
3. To consider themes arising out of appraisal of medical and dental staff
4. To oversee successful implementation of the online appraisal system
5. To ensure that the framework for supporting evidence and professional governance systems necessary to support revalidation are in place and fit for purpose including adequate resources
6. Ensure that appraisers and appraises are appropriately trained and that familiarisation on appraisal and revalidation is covered at medical induction.

## 18. Current risks for Medical Revalidation and Appraisal

The workforce within the Medical Appraisal and Revalidation at present has a stabilised workforce. The joint working with the Nursing Appraisal and Revalidation Team continues to provide resilience to deal with the workload challenges. The Consultant Lead for Appraisal is due to retire in March 2024, to date we have no replacement despite EOI advertisement.



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