Report of the
Urology Services Inquiry

Inquiry Website: www.urologyservicesinquiry.org.uk

Christine Smith CBE KC and Dr Sonia Swart MD FRCP FRCPath assert their right to be identified as the sole authors of this work, in accordance with section 78 of the Copyrights, Designs and Patents Act 1988. They wish to acknowledge the contribution of the Inquiry's Assessor, Mr Damian C Hanbury MS FRCS (Urol) to the work of the Inquiry and his assistance to the authors of this work.

ISBN : 978-1-912313-86-0

Printed in the United Kingdom by

Digital Print Services

of the Northern Ireland Department of Finance

Contents – Volume 4

Contents – Chapter 5 – Medical Management & Leadership

Medical management and leadership

Background

1. The way medical management and leadership operated at the Trust is relevant to many of the issues that led to this Inquiry being set up.

2. Over the last 40 years the importance of formally involving clinical staff and particularly medical staff in the leadership and management of hospitals and healthcare systems has been universally recognised in the UK and indeed throughout the world.[1] Studies show that hospitals that are clinically led, which usually means medically led, have better patient outcomes than those directed by professional managers. High levels of involvement of all doctors in contributing to and supporting the way the organisation works leads to better patient outcomes.[2]

3. There has been a gradual expansion of formal medical management roles in the last 20 years and, increasingly, there has been an understanding of the importance of benchmarked standards for medical management. This is endorsed by the General Medical Council (GMC) and the Faculty of Medical Management and Leadership.[3]

4. There is a need for specific development programmes for medical leaders who have well developed skills as doctors during their extensive training but who may

---

1 See: The Health Foundation Briefing. (September 2024) “Strengthening clinical leadership and management, Lessons from our research in the UK and US”. At: https://www.health.org.uk/reports-and-analysis/briefings/strengthening-clinical-leadership-and-management

2 See: Warren, O. J., & Carnall, R. (2011). “Medical leadership: why it's important, what is required, and how we develop it”. *Postgraduate Medical Journal*, at INQ-31060 to INQ-30166. See also: Clark J (2012), "Medical leadership and engagement: no longer an optional extra". *Journal of Health Organization and Management*, Vol. 26 No. 4 pp. 437–443. At: doi: https://doi.org/10.1108/14777261211251517

3 INQ-30846 to INQ-30866: GMC (2012) “Professional standards, Leadership and management”. See also: INQ-31002 to INQ-31008: Faculty of Medical Leadership and Management (2016) “Leadership and Management Standards for Medical Professionals” (2nd ed)

not naturally have had exposure to the theory and practice of management and leadership.[4]

5. Leadership and management development programmes for doctors are generally promoted as an important and essential component of Board supported organisational development strategies and implementation programmes. In general, the Medical Director and Director of Human Resources (HR) work closely to ensure that doctors understand the need for and the value of such programmes. These programmes require targeted funding and ongoing emphasis. Additionally doctors also often participate in multidisciplinary development of their teams. This helps to ensure that all the staff in a team and an organisation can work effectively towards a clear purpose.

6. The way medical management and leadership is approached and implemented varies widely in the UK and support is available through a number of agencies including The Kings Fund, The NHS Leadership Academy, regional leadership offers and the Federation of Medical Management and Leadership. Regional leadership offers are also available throughout the UK and are generally aligned to the needs of the organisations. In Northern Ireland this is provided through the HSC Leadership Centre.[5]

7. In the wake of recurrent patient safety failures in healthcare, there is increasing understanding of the need for compassionate leadership in a no blame culture with the concept of psychological safety being regarded as particularly important.

---

4 See: Darzi A. (2009) "A Time for Revolutions – The Role of Clinicians in Health Care Reform". *The New England Journal of Medicine*, Vol, 361 No.6 at INQ-31067 to INQ-31068.
See also: West, M. et al (2015). "Leadership and Leadership Development in Health Care: The Evidence Base". London, Faculty of Medical Leadership and Management. At: https://assets.kingsfund.org.uk/f/256914/x/6577e5c839/leadership_in_health_care_report_february_2015.pdf

5 The Leadership Centre's website can be found at: https://www.leadershipcentre.org.uk/

This helps staff to feel valued and helps to assure both staff and patients that there is meaningful learning and change when things go wrong.[6]

8. Doctors have a key role in shaping culture in healthcare and particularly in hospitals.[7] They are often looked up to as the natural leaders of their teams, where they make key decisions regarding diagnosis, treatment and development of services and can assist in supporting alignment and commitment of teams in an organisation.[8]

9. The GMC considers that all doctors have an important role to play in management and leadership and although some take on formal leadership roles, it is expected that all doctors should show leadership in their teams and develop management skills. These expectations are set out in Good Medical Practice (GMP) as referenced elsewhere in this Report.[9]

10. There are a variety of ways that medical management and leadership roles are structured in an organisation but increasingly there is an expectation that job descriptions are set out clearly and that sufficient time is allocated for the duties required. This represents a big challenge when there are often shortages of doctors and when there are ever growing demands for healthcare. The pressure to prioritise patient care understandably often displaces the requirement to perform any other duties in many settings.

---

6 See: Grailey, K. E., et al (2021). "The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis". BMC Health Services Research, (2021) 21:773. https://link.springer.com/article/10.1186/s12913-021-06740-6; and
Newman A., et al (2017). "Psychological safety: A systematic review of the literature". Human Resource Management Review, 27(3):521-535. At: https://www.sciencedirect.com/science/article/pii/S1053482217300013

7 INQ-20577 to INQ-20605, Department of Health and Social Care. (2022). "Health and social care review: leadership for a collaborative and inclusive future". Independent report from General Sir Gordon Messenger and Dame Linda Pollard into leadership across health and social care in England.

8 See: Drath, W. H., et al. (2008) "Direction, alignment, commitment: Toward a more integrative ontology of leadership". The Leadership Quarterly, 19(6), 635–653. At: https://www.sciencedirect.com/science/article/pii/S1048984308001252?via%3Dihub

9 See Clinical Aspects chapter

11. Most medical management structures consist of an operational manager, a medical manager and a nursing manager at each level of an organisation. These triumvirates are jointly responsible for decisions and meet to reach decisions based on an agreed set of information. These groups would also deal with ad hoc issues and problems and document their decisions appropriately. In some structures the medical manager has responsibility for the budget, the operational performance and the clinical standards and is supported by a professional manager and a nursing manager. In other structures the overall responsibility rests with the operational manager. Dr Richard Wright alluded to this in his oral evidence as referenced in paragraph 51 below where he discusses the benefits of encouraging strong medical leadership by giving doctors financial responsibility.[10]

12. Whatever structure has been agreed in an organisation, the Board and executive level leadership are accountable for quality and safety. In practice this accountability generally rests with the Medical and Nursing Directors, although the whole Board shares this responsibility. The Medical Director must also provide assurance in relation to the professional standards for doctors including appraisal and job planning and in most Trusts is designated as the Responsible Officer (RO) who makes recommendations on revalidation to the GMC.[11] At each level of medical management there is an expectation that oversight of professional standards for doctors is the responsibility of the medical manager who should also understand how to escalate any important issues giving rise to concerns relating to the clinical practice of doctors.

13. In a well-functioning management structure, operational managers should support medical managers in dealing with concerns and should have training and awareness in relation to the professional standards expected of doctors.

14. Medical management and leadership roles are very demanding and are almost always layered on top of busy clinical jobs. Although Medical Directors generally

10 TRA-02523, lines 19 to 28
11 See paragraphs 250 to 259 below

do very little or perhaps no clinical work, most other layers of medical management continue to practice clinically. This helps them stay connected to the clinical workforce and preserves career opportunities but provides a risk to their ability to execute all of their duties, unless they are provided with a suitable support structure. As Dr Wright explained in his evidence, all medical managers need to be able to balance the:

> "tension between delivering a clinical service and maintaining high safety and quality standards."[12]

The approach of the Inquiry

15. The Inquiry sought to determine to what extent the Trust had supported and acknowledged the importance of investing in medical leadership, its development and how this operated in practice in urology and the Acute Directorate and by implication more generally across the Trust.

16. The Inquiry was particularly interested in the views of personnel in the period leading up to and during the Inquiry. We heard from both operational and medical managers in the Acute Directorate and Urology and from the Chief Executives and Medical Directors. Dr Maria O'Kane had a unique perspective as she took on the Medical Director role in 2018 and became Chief Executive in 2020.

17. The Inquiry approached the evidence in this area by considering whether the Trust provided the essential components required for medical management and leadership to thrive, and how this manifested in the management of the Trust more broadly. We looked to see whether there were any signs of problems in medical leadership as exemplified by medical management in Urology and the Acute Directorate.

18. The Inquiry sought to answer the following questions concerning the conditions required for medical leadership to flourish:

[12] See Dr Wright's oral evidence at TRA-03284, lines 25-27

- Was there a clear organisational vision and series of overarching aims based on the primacy of the quality and safety of services, including a focus on learning and on respect such that medical staff felt connected to the organisation as a whole while striving to deliver high quality care?
- Was there a clear organisational structure with defined links between operational and clinical managers and between layers of management control, and was there evidence that these were working effectively to resolve problems at each level?
- Was there clarity of responsibility for all medical management and leadership roles?
- Was there sufficient time allocated for medical management roles?
- Was there an adequately funded ongoing development programme for all medical staff in leadership roles to include consultants, Clinical Leads (CLs), Clinical Directors (CDs), Divisional Directors and Medical Directors all set in the context of an organisational development?
- Was there sufficient clinical and specifically medical involvement at Board committees beyond that of the Medical Director, so that the clinical voice at the Board was strong and covered the breadth of current clinical practice?
- Was there a well-developed strategic planning framework which included all medical leaders? How well did all senior medical staff feel connected to long term planning for their services and for the Trust as a whole?
- Was there clear leadership for safety and quality from the Board Medical and Nursing directors with articulation of responsibilities for key elements such as learning from incidents, complaints and national audits, for example?

19. The Inquiry wished to learn whether medical leaders were regarded as integral to shaping the culture of the organisation and were willing and able to continually reinforce alignment between what the organisation was trying to achieve and the day-to-day reality of their work as front-line clinical staff.

20. The Inquiry sought to understand how well medical leaders were valued and respected by consultant colleagues at service level and how well they

themselves felt valued and listened to by their colleagues. As part of this we looked to assess the appetite for medical leadership roles and whether these leaders felt empowered and part of an important group of senior doctors.

21. It was also necessary to ascertain whether there was clarity regarding who should deal with concerns relating to doctors, who should deal with safety and quality concerns and how these concerns should be raised and resolved.

22. The views of medical managers and consultant medical staff with respect to cycles of job planning and appraisal and the support and oversight of these processes was also important in the understanding of how well these tools were used at the Trust.

23. The Inquiry was also interested in whether there were any warning signs that medical leadership and medical engagement generally might be in need of improvement. These include several areas which would apply to all managers, but which would be particularly likely to affect medical staff who take on leadership roles alongside a busy clinical workload. This empirically could include for example:

- The presence of organisational structures which work on paper, but in practice feature disconnects in terms of professional managers and doctors such that there are silos of management with respect to issues or a feeling of a clinical/managerial divide.
- Regular requests for additional clinical work to deal with waiting lists or to cover absent colleagues, squeezing the time available for medical management roles, which are layered on top of already busy jobs.
- Absence of medical staff at key meetings due to work pressures.
- A lack of succession planning with vacant medical leadership roles.
- Poor handover from one medical manager to the next often exacerbated by high turnover in these difficult roles.
- A lack of distributed medical input into annual and longer-term strategic planning so that consultants do not feel involved.

- A domination of discussions relating to access targets or money with these taking priority over discussions about quality of service.
- Lack of medical involvement in financial decisions.
- Lack of distributed broad medical input into directorate or Trust wide key quality and clinical outcome measures and audit.
- Failure to manage longstanding issues in relation to individual doctors or groups of doctors due to established hierarchies.
- Doctors feeling disconnected from 'management' or 'the Trust'.

Medical leadership and management in Urology, the Acute Directorate and the Trust

The Trust structure and operation of medical leadership

24. The Trust clearly recognised the value of medical leadership and had developed and adapted a medical management and leadership structure over time. This was evolving at the time of the Inquiry's work.

25. The Trust supported the concept of a range of medical management roles and understood the importance of defining these, although until Dr O'Kane took over as Medical Director in late 2018, the content of job descriptions remained inconsistent and the overall investment in medical leadership was light compared to other similar organisations. The structure in 2018 had fewer medical leadership posts than when it was originally agreed in 2011 and had not been formally reviewed since that time. [13]

26. There were direct reporting lines through a range of medical management posts from the services through to the Medical Director for professional issues relating to medical staff and for serious safety and quality issues. The Director of Services covering each section of the Trust took responsibility for all other issues and had

[13] See: Medical Leadership Review 2018 at WIT-31532 to WIT-31569; WIT-46907 to WIT-46909 refers to "Medical Leadership Structure Today" dated May 2019 but relates to the structure in 2018

overall responsibility for the operational, financial and quality performance of that section and reported directly to the Senior Management Team (SMT).

27. In each Directorate there was a line of reporting from the service through a Head of Service (HOS) post to the Director of Services and a parallel line of reporting for medical staff through a CL and CD to the Associate Medical Director (AMD). The Medical Director coordinated and supported the medical management activities in the Trust with assistance from others as required.

28. Professional managers and medical managers generally described good working relationships and there was frequent reference to informal conversations as an integral part of the way things worked.

29. The Trust also had a structure of meetings supporting reporting lines to the SMT and the Trust Board. In relation to the connections between the Acute Directorate and the SMT there was also a reliance on informal mechanisms.

30. In differing ways all the medical directors and other medical managers we heard from referred to many challenges and difficulties. These related to clarity of accountability; the dominance of financial and operational pressures; relative underinvestment in audit, governance and data systems; insufficient specific, relevant training in management and leadership; poor handover and development; and a very significant underinvestment in the time needed for medical leadership and management to support and develop all these areas.

31. Cultural issues were identified by both operational and medical managers including a reference to 'silos' of management as mentioned elsewhere in this Report.[14] Excessive hierarchy was referred to by Ms Heather Trouton during her time as Assistant Director when she reflected that:

[14] See the Governance chapter and paragraphs 23 and 186 of this chapter

"within the hierarchy, and certainly at that time, I didn't feel I could go outside of those two lines".[15]

Deference to doctors, especially senior doctors also featured. These issues could all cause difficulties in supporting an open culture focused on safety and quality, where openness, an absence of blame, psychological safety, learning and shared responsibility are required. These matters are of general importance for the Trust leadership teams but have a specific relevance for medical staff.

The role of the Medical Director

32. The Medical Director at the Trust is a full member of the Trust Board and was clearly valued as a source of professional advice. The Inquiry received evidence from a series of medical directors including Mr Patrick Loughran (2007-2011), Dr John Simpson (2011-2015), Dr Wright (2015-2018), Dr Ahmed Khan (2018, as interim) and Dr O'Kane (2018-2022) who then became Chief Executive and the Accountable Officer in 2022.

33. The role of the Medical Director as the professional lead for doctors, strengthened through the responsibility for medical revalidation, appraisal and job planning for doctors, was clear. This role also covered responsibility for leading the development of management and leadership for doctors whether they were formal managers or not.

34. The Medical Director had overall responsibility for governance in the Trust and was designated as the lead for quality and patient safety including clinical audit.[16] This is a key responsibility in terms of supporting a culture of learning from error and assuring high standards of care.

15 TRA-02340, lines 2-4
16 See job description at TRU-101577 to TRU-101585

35. The Inquiry recognises that the range and complexity of these duties cannot be delivered without significant support in terms of effective data and governance systems, and clear supporting leadership roles.

36. Prior to the events leading up to the Inquiry, the role of the Medical Director did not benefit from a suitable range of deputies to assist with this extensive range of responsibilities. Given the size and complexity of the Trust, the Medical Director would not have been able to fully discharge these duties without a proper support structure. Such a support structure would usually be provided by a range of Deputy or AMDs as well as administrative staff.

37. The Medical Director was the only doctor on the Board. Some Medical Directors felt that this was not sufficient given the complexity and size of the Trust and the need for clinical input to a very broad range of decisions.[17] The Inquiry agrees.

38. Dr Wright reflected the need for more senior medical leadership support in his evidence:

> "From my own office, at that point the Medical Director's office was essentially composed of myself … It was very underresourced [sic] ... I had highlighted this issue before I left the Trust with a paper to try and bring forward appointments of more staff to help with this, in particular, with Deputy Medical Director posts".[18]

39. Dr Wright also commented on a specific issue which from his perspective was in need of improvement stating:

> "I certainly raised the need to bolster the resource within the Medical Director's team for seeking assurances in different ways."[19]

17 See paragraph 92 of the Governance chapter
18 TRA-03207, line 28 to TRA-03208, line 6
19 TRA-03270, line 28 to TRA-03271, line 1

This echoes the statement made by Dr O'Kane relating to the difficulty in obtaining data.[20] The ability to oversee safety and quality would have been significantly impaired by this deficit.

40. When asked about what would be needed to improve matters Dr Wright stated:

> **"**I think there would have to be the ability and the capacity to be much more proactive about seeking assurance. That requires manpower, training and expertise. And expertise not just on measuring data off a number of files lying in a cupboard but expertise in human factors training, root cause analysis, some of these analytical tools that have been shown to be so valuable but where the skill base is very weak, certainly in this part of the world."[21]

He went on to say that the culture in Northern Ireland has not supported the provision of data relating to clinical outcomes for individual doctors and said:

> "There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful."[22]

41. Dr Wright links cultural problems with the lack of focus on assurance. He goes on to reflect his view of other cultural issues relating to medical management. He is of the opinion that investment in medical management requires a change in the way it is viewed stating:

> "But it's not just about the money, it is about seeing how they are valued and their views expressed.

---

20 See paragraphs 143, 244, 286 and 494 of the Governance chapter
21 TRA-03270, lines 14-22
22 TRA-03274, lines 4-11

> I do think there was a bit of a culture within the Southern Trust, as in the health service in Northern Ireland generally of keeping doctors out of positions where they could actually take decisions. That's my personal view. I think that's been unhelpful and we need to get a more mature view where they can feel engaged. I think that is beginning to happen."[23]

42. The importance of culture in relation to medical management was also articulated by Dr O'Kane. She remarked that when she joined the Trust:

> "the culture throughout the organisation was that the relationship between medical leaders and operational leaders wasn't a partnership, you know that - and I think it was borne out of a lack of understanding I think at times of what that partnership could actually bring, but also I think an anxiety about, you know, making appropriate demands on the relationship, because I do think - my sense is that the managers within the Southern Trust at a point in time I think felt that they were, you know, encroaching on even medical leaders to ask them for help, and then vice versa, I think often the medical leaders didn't automatically recognise it was their role to become involved. And, you know, the pattern at times seemed to be that when there was a clinical crisis of some description where they needed medical involvement then the doctors were asked for help, but usually outside of all of that it didn't seem to work as a partnership."[24]

43. Dr Wright introduced improved training for medical managers. He explained that when he arrived, in 2015, he discovered there were issues in terms of recruiting and retaining medical managers. He realised that more training was required. He set out to improve not only medical managers' understanding of how to do the job but he also sought to energise them and increase appetite for undertaking these very difficult roles. He told the Inquiry:

---

23 TRA-03268, line 29 to TRA-03269, line 10
24 TRA-11693, lines 2-20

> "it was challenging to fill those posts, and it took quite a wee while before we had a static workload or workforce in those posts. I think there had been difficulties in the past with relationships within the Directorate between individuals and between some of the surgical team which didn't help things and took a while to settle down, it's probably fair to say. I like to think that the opportunities for people filling those posts were improved by the amount of training we did over three years that I was in office with doctors who were interested in management roles. This was something they had sought and we designed a bespoke training programme around clinical management for doctors, in association with the Leadership Centre and our own Human Resources Department to try and fill the gaps that they saw in their own training and to encourage medical management as a possible career path."[25]

Notably in the Acute Directorate there was a critical period of a year during 2016-2017 when there was no AMD in post and there were often CD vacancies.

44. The issue with insufficient training for medical management posts continued despite Dr Wright's efforts. Dr O'Kane commented on this stating:

> "Medical Leaders also had not traditionally had much in the way of formal training or induction to their roles and as such at times struggled to provide leadership."[26]

45. Dr Wright set out to improve the way the AMDs and other senior medical managers worked together realising that a sense of better collegiate working amongst medical managers was part of the culture change that was required. He stated that:

> "When I initially came to the Trust in July 2015, it became apparent to me that there was a lack of trust between Consultant medical staff and some of the senior medical and non-clinical leaders over a number of preceding years.

25 TRA-02503, line 22 to TRA-02504, line 10
26 WIT-45063, paragraph 46.1

This seemed to be an issue particularly within the surgical and anaesthetic teams."[27]

In oral evidence he told the Inquiry:

"I remember … my first Associate Medical Director team meeting and being surprised at just the general atmosphere within the meeting, which was not open and appeared to be quite defensive."[28]

He then described his own approach saying that his:

"modus operandi was that we were a team … there was to be cross-cooperation between the AMDs and mutual support, and that was the way they were going forward."[29]

46. Dr Wright recognised that in a general sense it is often challenging for doctors to manage senior doctors and remarked that:

"Mr O'Brien was probably the most senior colleague in the entire Trust which was an added factor. This may have led to a reluctance for medical staff to escalate some significant issues."[30]

47. An inherent tension in medical leadership is the difficulty doctors may have in challenging close colleagues on whom they rely. Mr Eamon Mackle who was AMD for Surgery and Elective Care (SEC) in the Acute Directorate from 2008-2016, referring to the many informal relationships between colleagues that help ensure patients get multidisciplinary input from a range of clinicians when they need it, told the Inquiry:

27 WIT-17894, paragraph 67.3
28 TRA-02511, lines 23-27
29 TRA-02512, lines 21-25
30 WIT-17894, paragraph 67.3

> "it is harder to do a full-on challenge when you need people giving you advice and helping with your own patients. I think that is probably one of the biggest things that is hard to divorce, you know, from being a manager having to at the same time making sure your patients get the best possible deal in the end."[31]

48. Dr Wright also recognised the importance of training in management both for medical leaders and for the non-medical managers who would need to support the processes such as MHPS (Maintaining High Professional Standards). He stated:

> "There was also a lack of knowledge among many of the medical and non-clinical leadership staff regarding possible options open to them for dealing with difficult issues among colleagues."[32]

He added:

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

31 TRA-02102, lines 1-7
32 WIT-17894, paragraph 67.3

that in a number of previous areas where that has worked well, and I have seen the effects where not doing that has led to very significant problems".[33]

In relation to the senior clinical staff including Mr Mackle, Dr Wright commented:

"You can't have an Associate Medical Director who is ultimately unfamiliar with the MHPS process, which again is one of the reasons why we developed a bespoke training programme for them because it was apparent that there was a deficiency of knowledge amongst senior clinical staff in that area".[34]

49. Although Dr Wright was referring to MHPS it is clear that there was a more general problem in terms of how to use what might be described as normal medical management tools to assist in dealing with performance matters. This was also referenced by Dr O'Kane in her evidence when she spoke of the difficulties in managing Mr O'Brien who she described as very unusual in his approach. She then went on to postulate why the medical management chain had not been able to resolve issues over a long period of time stating:

"I think what made the job of managing more difficult, … among other things, was a concern throughout the system about Mr. O'Brien's connections. You know, one of the first things I heard about him was he had legal connections. Then the other thing I heard about him was that he was a close friend of the Chair of the Trust. I think that put people off, actually, challenging him. You know, what they would have said to me was he made threats back to them about who he was connected with and how he would get them into trouble if they challenged him in any shape or form."[35]

In one sense these indications came to Dr O'Kane in the form of rumour or hearsay, and the Inquiry did not receive any evidence of specific direct threats made by Mr O'Brien, however the rumours of same clearly made an impression

33 TRA-02513, lines 7-29
34 TRA-02514, lines 23-29
35 TRA-01460, line 24 to TRA-01461, line 7

on Dr O'Kane. Then, in January 2019 at Dr O'Kane's first meeting with Mrs Roberta Brownlee, Dr O'Kane recalls that:

> "she made comment about the fact she felt he had been essentially persecuted by my predecessors, he was an excellent Surgeon and a good man, and she hoped I wouldn't treat him in the same way."[36]

When questioned by Inquiry Counsel:

> "Q. Would it be fair to say that those concerns that you heard about Mr. O'Brien, or the perception he may have had some sway, either personally or professionally, operated a chill factor in dealing with him?
> A. Yes, it did. Definitely."[37]

More is said about Mrs Brownlee's relationship with Mr O'Brien and how she advocated for him in the Governance chapter.

50. In order to deal with such situations, it is particularly important that medical managers receive ongoing training and support from HR. They must understand how to access and use all management tools and policies and, very importantly, understand their core duty is to protect patients.

51. Dr Wright made significant comments regarding the issue of clarity of accountability which are relevant to the way medical leadership operated generally in the Trust. This relates to the fact that the medical management posts did not hold overall responsibility for a service, a group of services or a directorate. Instead, this was held by Director of Services for each section of the Trust. There were in fact two parallel lines of accountability for medical managers – one through the Director of Services to the SMT and the Board and one through the medical line to the Medical Director. When asked about this Dr Wright stated:

---

36 TRA-01461, lines 14-17
37 TRA-01461, lines 21-26

> "In the days when I was Clinical Director in Radiology,[38] the Clinical Director of the Department would have been the budget-holder in the Department and was Head of the Department and was responsible for everything within that. They would have clinical standards. They carried the can for the budget, for the staffing levels, everything. It was very clear who was in charge and who to go to if there was a problem. We have a system now where that is not so clear. … where relationships are not so good and the clinicians and the individuals are very busy and under a lot of stress, that system cannot function as well. My personal view is, the dual line can be confusing on occasions and isn't helpful in this type of situation because, in reality, there is a blur between professional and operational matters."[39]

52. When Dr O'Kane joined the Trust and developed further plans for medical leadership, she also recognised this problem and made efforts to clarify accountability. She outlined her desire to move to a more traditional triumvirate structure where the divisional medical manager, the professional manager and importantly a divisional nurse, were held jointly accountable to the SMT through the Director of Services.[40]

53. When the MHPS process was commenced in 2016-17 the terms of reference for the investigation were broadened to include an investigation into the actions of management.[41] Strictly speaking, an MHPS process ought to focus on the performance and professional standards of the clinician. It should not have been used, as it was here, to document the shortcomings of management actions, although it is acknowledged that an investigation of this kind would inevitably touch upon the interventions of managers. The Inquiry is of the view that the actions of management who engaged with Mr O'Brien did need to be thoroughly investigated but that this should have been carried out as a separate process and with some urgency. We note that the MHPS determination recommended a formal review of the management processes in the Acute Directorate. Dealing

38 This was in a different trust
39 TRA-02523, line 19 to TRA-02524, line 17
40 WIT-45167 to WIT-45168
41 This is discussed at paragraphs 217 and 218 of the MHPS chapter

with this separately would have simplified the MHPS investigation and reduced the delays. The formal investigation of management processes never in fact took place. Had it been completed with speed at the time, the Inquiry is of the view that it might have unearthed some of the issues relating to the operation of medical management, the lack of connections between medical and operational management, as well as the need for more effective support for governance and analytical data. This was a missed opportunity.

54. Dr Wright made significant comments regarding the time allocation for all medical managers which was endorsed generally by all the medical directors, professional managers and medical managers who gave evidence to the Inquiry. He stated:

> **"**One of the main stumbling blocks, I think, would have been the amount of time and resource given to clinicians wanting to take on those roles. There would have been limited programmed activity or PA allocations for them and limited administrative support staff to help them in the roles. Part of this was because of funding issues, but, to be fair, a large part of it would also have been the clinicians themselves who really didn't want to give up significant parts of their clinical practice to take on these roles. They would prefer to do them on top of full-time posts."[42]

55. Dr Wright was referring to the unwillingness of many clinicians to give up clinical work, thereby limiting their time and commitment for the important business of management and leadership. Mr Mackle explained the dilemma:

> "The role was extensive. The job description is extremely extensive. The role was extensive but this was on top of being a full-time clinician. Part of that was - and I said at the time I was asked to take it up, would I apply for it - if I had given up my subspecialists, I would have had more time but if I ceased to be AMD, I couldn't take those back up again. That was my priority; my priority

[42] TRA-02504, lines 10-21

was the surgical work which I did with my patients for oesophageal surgery and for colorectal."[43]

56. In addition, the practical reality of the extensive clinical work pressures at the Trust would have had very significant implications for any medical management role because many clinicians, including the medical managers, took on additional clinical work to ease waiting list pressures.

57. The instability of the Trust's SMT referred to earlier in this chapter included a significant turnover of Medical Directors and other senior medical management posts as well as changes in key director level posts in the Acute Directorate. The Director of Acute was Dr Gillian Rankin from 2011-2013, then Mrs Deborah Burns 2013-2015, Mrs Esther Gishkori from 2015-2020 and then Mrs Melanie McClements 2020-2022. This degree of turnover inevitably causes a measure of instability which is clearly disruptive and has a detrimental effect on organisational memory.

58. Medical managers indicated that there were insufficient handovers and induction for new medical managers including at Medical Director level.[44] The lack of clear documentation for some key decisions, such as the advice provided by Dr Wright to Mr Mackle leading up to the March 2016 letter, accentuated the risk of failure of organisational memory in this situation. So, for example, Dr O'Kane, when she was presented with the information relating to the MHPS investigation for Mr O'Brien was not presented with all the available information dating back at least to 2009:

> **"**In hindsight, knowing now what I know, these difficulties were going back to at least 2009 and that, actually, you know, these were symptoms of something

43 TRA-02077, line 24 to TRA-02078, line 4

44 At TRA-01424 to TRA-01425 Dr O'Kane described a short handover and induction. See too evidence of Mr Weir at TRA-02727 to TRA-02728 and Mr Haynes at WIT-53884; WIT-53922; WIT-53937; TRA-00845

else, not what they looked to be on the face of it. I think I would have approached it differently."[45]

59. Doctors were held in high regard at the Trust and there was an accepted understanding that senior doctors were due respect. Dr Neta Chada referred to this indirectly in her evidence relating to the MHPS investigation:

"I did wonder whether he might feel that I was a bit of a whippersnapper. I did wonder whether he might feel that because of the fact that he was really quite senior to me in terms of experience and years. So, I did wonder about that. As I say, knowing that he was quite a formal, proper gentleman".[46]

The view of the administrative staff in relation to the status of doctors generally was significant. Mrs Katherine Robinson, who was Medical Records Manager and also the Head of Acute Referral and Booking Centre and Secretarial Admin was referring to doctors when she said:

"you see them as 100 times more important than we will ever be."[47]

60. Dr Wright summed this up when he was asked why there had been a failure to put quality and safety at the top of the agenda in the period leading up to the MHPS investigation saying that this had at its core an:

"Inappropriate deference based on status rather than ability."[48]

61. Dr Khan was acting Medical Director from January to December 2018 having also been the Case Manager in the MHPS investigation. Although he was in post for a relatively short time, he prioritised work on the development of medical leadership, taking up the issues noted by Dr Wright and laying the groundwork for subsequent work. He noted:

45 TRA-01517, lines 5-9
46 TRA-03658, lines 16-22
47 TRA-05234, lines 28-29
48 TRA-03285, lines 14-15

"a lack of focus in developing medical leadership in the Trust"[49]

at that time and made a compelling case for change in his well evidenced paper entitled "Medical Leadership Review"[50] presented to the SMT in various forms over the Autumn of 2018. This paper noted that there had been no review of medical leadership since 2011 and stated there was a need to improve the structure of medical leadership as well as enhance training, succession planning and accountability. The aim of his paper was to ensure a situation where leadership roles are clearly defined, with responsibilities mapped to national frameworks, where leadership development is formalised and competency-based, where accountability and assurance are built into the structure, with regular reporting and audit and where all clinicians are expected to demonstrate leadership, not just those in management roles.

62. A further refinement of this paper developed in 2020 by Dr O'Kane[51] made further detailed suggestions specifically recognising the need for consistent job descriptions, more posts, more time and more training and support. An update on developments in this area in 2021 included a revision of the CD role.[52]

63. Some investment in medical leadership and management was agreed in 2018 with the appointment of two Deputy Medical Directors, some additional time for CDs and support for morbidity and mortality meetings. This was extended after Dr O'Kane's work resulting in the recommendation of a much more extensive medical management contribution.[53] Specifically, she increased the number of AMDs in Surgery from one to two and made efforts to improve the way medical and operational managers worked together to take joint responsibility.[54]

49 WIT-31105, paragraph (2)a
50 WIT-31532 to WIT-31569
51 WIT-46896 to WIT-46938
52 WIT-46939 to WIT-46953
53 WIT-46916 to WIT-46920
54 TRA-11695; See also paragraphs 72 and 82 below

64. Dr O'Kane also recognised the need to reduce the size of the Acute Directorate. This was divided into two, requiring realignment of governance posts.[55] She also ensured that she built on the work of previous Medical Directors to improve training for doctors in leadership roles with mandatory training, for example, for many roles in the area of managing concerns.[56] She was specifically concerned to ensure that doctors as well as other staff were better equipped to understand how to address concerns and difficulties in relation to medical staff. This included setting up a range of meetings where such matters could be discussed and with clear signposts to professional advice.

65. Dr O'Kane recognised that there was significant work to do in relation to the culture within the organisation generally and made efforts to ensure that there was a better understanding of the fact that despite the various difficulties, medical managers had an important role to play and needed to work with and alongside other managers. She stated:

> "there was an ambivalent attitude towards medical management across the organisation in relation to managers who felt, you know, the sense - and I think this was, you know, part of the culture, that the doctors were there to see the patients and get on with it and actually all the management decisions should be left to other people. I think … the point in having a collective approach to this is to bring, you know, the expertise and the knowledge and skills all together in the one place across the different disciplines, and I am very firmly of the view that doctors should be leaders in all of that."[57]

66. The work on culture became a specific focus once the Inquiry was launched and led to a number of significant recommendations following the work of the External Reference Group (ERG)[58] as quoted in paragraph 206 of this chapter.

---

55 TRA-11776 to TRA-11777
56 TRU-305570 to TRU-305571
57 TRA-11689, lines 11-23
58 TRU-303678 to TRU-303720, See also paragraph 17 of Governance chapter

67. Despite many improvements and training in place the Inquiry was told by Dr O'Kane that there is as yet no Board agreed, funded, ongoing, organisational development programme of work with a specific focus on medical leadership.[59]

68. Part of the improved focus on medical leadership and management has been recognised as the requirement for an improvement in the use of job planning and medical appraisal as tools for medical management and development of doctors generally as described later in this chapter. This work is underway and the need for greater clarity in terms of setting clear objectives, development needs and appraisal for medical managers will also be important.

69. The expanded medical management roles now in place, the understanding of the need to develop and use all the tools of medical management, an improved approach to training and development and the increased support for the Medical Director should in time allow a more coherent approach to medical management and leadership. The improvements in Medical Professional Governance are outlined by Dr O'Kane in her witness statement[60] but more is said about them later in this chapter. Specifically, in the Inquiry's view, improved medical leadership including the oversight of key quality and safety issues is a critical part of the many improvements which the Trust is in the process of implementing. In terms of encouraging doctors to lead effectively, the Trust's work on cultural reform, the Board's understanding of the need for a clearer vision with an increased emphasis on patient safety and improvements in governance have to be important components of an ongoing improvement programme.

Medical management in the Acute Directorate and the interface with the Medical Director and Senior Management Team

70. The most senior medical manager covering surgical disciplines in the Acute Directorate was the AMD for SEC. That role included supporting the Director of Acute Services with any issues relating to the professional behaviour of medical

59 TRA-11922
60 WIT-45014 to WIT-45016

staff in surgical specialties. It also included providing advice on the development of services and had a key role to play in a number of aspects of clinical governance, including the classification and oversight of serious incidents and any critical patient safety risks.[61]

71. The role was described by Mr Mackle. He articulated the important contribution of the AMD in assisting and leading in the development of strategy as:

> "leadership and advice to management; advice to management how we could help develop the service. This was the start of the new Trust when we had combined with Daisy Hill. So, Craigavon Area Hospital Group Trust became the Southern Health and Social Services Trust. So it was that stage advising how we could work, how we could integrate, how we could develop the services."[62]

72. During the period 2008-2016, Mr Mackle was AMD for Surgery in the Acute Directorate. He was succeeded in that role by Dr Charles McAllister for a period of six months and then after a gap of a year, by Mr Mark Haynes who started the role in 2017 and continued until 2020 when he took on a specific role as AMD in relation to improving Urology. Following improvements in the medical management structure, the number of AMD posts in surgery was increased. The titles were changed to Divisional Medical Directors and the job descriptions and responsibilities were clarified.

73. AMDs reported to the Medical Director for professional medical issues and any serious quality issues that they felt needed highlighting. They were the line managers for CDs and CLs who provided the medical management input at service level. They reported to the Acute Director for all other issues. Clearly there were some issues which did not fall neatly into one category or another.

61 WIT-11836 to WIT-11840
62 TRA-02076, lines 19-26

74. Most of the medical management roles in the Acute Directorate had job descriptions although historically these were not necessarily consistent. The Inquiry noted that a number of CLs did not have job descriptions at all and not all CDs were issued with job descriptions when they started their positions. Generally, however, medical managers felt they knew what was expected of them, even if they felt they could not fulfil all the duties required of them. There were often vacancies in posts especially at CD level.

75. There was no set procedure for induction, handover or training for new medical managers at any level, although training was put in place at a number of points over the years and in response to new procedures or important issues. This has improved in recent years following the early attempts by Dr Wright and the need for induction and training is now well recognised.

76. There was no formal process for appraisal of medical management roles.

77. Each of the AMDs in the Acute Directorate had observations to make in their evidence which were pertinent to the matters before the Inquiry and their views supported the concerns expressed by the Medical Directors in terms of the challenges of medical management. They reflected problems relating to insufficient time, training and development, supporting infrastructure, culture, operational and financial pressures and workforce issues. Many of these challenges are widespread throughout the Health Service in Northern Ireland and in the NHS generally.

78. Both Mr Mackle and Mr Haynes confirmed that the time required to properly fulfil the duties outlined in the job descriptions was insufficient. This had the general effect of creating an acceptance of the fact that medical managers would concentrate on priority issues within the time they had but would not be able to do everything.

79. Both professional and medical managers accepted that the medical managers would not always be able to attend regular meetings such as for example the weekly governance meeting. Mr Haynes acknowledges this specifically stating:

> "The Acute Clinical Governance meeting, which was one of the meetings I have mentioned earlier in relation to SAIs, takes place on a Friday morning at the same time as I have an operating list in Belfast Trust which makes it very difficult for me, certainly made it very difficult for me to attend".[63]

80. Mr Mackle when asked what would improve the AMD role said:

> "I think the biggest one is time, time to do the job and do the role. … Should it be almost 50/50? Probably should"[64]

and he acknowledged that it was:

> "difficult prioritising everything, to be honest."[65]

81. The individuals in these posts presented themselves as highly committed and willing to work over and above their allocated hours. They did not seem to fully appreciate that better combined operational and medical manager input to all critical meetings might have had a significant positive input. Instead, they in general accepted that they did the best they could within the limited time available. Mr Haynes stated:

> "I did what I was able to and what I needed to, often working in my own time, and indeed I often displaced some of my own clinical work into my own time in order to enable me to deliver activity as AMD."[66]

Further reflections included the comment that:

63 TRA-00836, lines 23-29
64 TRA-02099, lines 7-19
65 TRA-02086, line 25
66 TRA-00835, lines 13-16

> "in order to provide leadership as a Clinician, the Clinician needs to, in some way have, if you like, that respect of the team. You need a Clinician who is a Clinician in a Clinical Management position. Ultimately, on this subject, I think we would need to be stronger in our expectation of Clinicians that actually in order to take this on you need to withdraw from being the full-time Clinician that you are."[67]

This comment effectively acknowledges the responsibility of doctors in these roles to recognise the need to formally devote more time to their managerial duties.

82. Recognising the need for shared responsibility for decisions, it is notable that Dr O'Kane describes a situation where, as part of improvements, medical managers are now asked to attend accountability meetings alongside operational managers.[68]

83. The operational managers accepted the situation and had variable views on how problematic they found the lack of medical input. Mrs Gishkori, Acute Director 2015-2020 told us:

> "Mark Haynes was the AMD for urology. We were supposed to meet monthly however he rarely attended scheduled meetings and he rarely attempted to make any informal contact with me. He was unable to provide time."[69]

84. Mr Haynes disagreed with her view saying that he had frequent informal contact. In any case there was general agreement that informal relationships between professional and medical managers were good. The Inquiry interpreted this as indicating that there was little conflict at this level even if the time commitment was problematic.

---

67 TRA-00839, line 26 to TRA-00840, line 5
68 TRA-11696 to TRA-11697
69 WIT-23380, paragraph 47

85. The AMDs recognised that support for their role was critical and in need of improvement. They valued the support that they had from operational managers. Mr Mackle stated:

> "I had significant support from the heads of service and the Assistant Director, and the Director. I was actively supported by them but they also had a significant operational role. There was no other role -- nobody supplied to support the associate medical directors in their role as Associate Medical Director, purely driving that forward. That didn't exist. There was nobody there who said -- you know, I think that's the big -- that area, I think, was missing, an active support for medical directors -- or associate medical directors rather than just the operational support, which I appreciated and got a lot of."[70]

86. Mr Mackle, when asked if he felt he was supported by the Medical Director said that he felt "moderately supported"[71] and went on to say that he had expected more of an interpersonal relationship.

87. Dr McAllister took over as AMD for Surgery as an additional role because of the vacancy left when Mr Mackle retired. He describes the support from the Medical Director as "Not as much as would have been helpful"[72] with too few one-to-one meetings.

88. Shortly after taking on the role, Dr McAllister sent the email to the Medical Director and others, referred to elsewhere in this Report.[73] He had been given a verbal handover by Mr Mackle, but it was only a few weeks later that Dr McAllister realised there were many problems.[74] The email listed 21 concerns covering a range of serious governance issues encompassing problems with: a variety of

70 TRA-02099, line 20 to TRA-02100, line 3
71 TRA-02098, line 20
72 TRA-02738, line 20
73 WIT-14875 to WIT-14876. See also paragraph 28 of the Governance chapter
74 See paragraph 28 of the Governance chapter

services including urology; junior and middle grade doctor rotas; consultant job plans; poor attendance at meetings for CLs; assurance regarding consultants looking at radiology results; a lack of theatre capacity; and a backlog of incidents that had not been classified, including Serious Adverse Incidents (SAIs). Despite the fact that Dr McAllister says he was **"**horrified"[75] and despite his view that there was a:

> "lack of overall structures for ensuring practical and effective governance"[76]

his email did not trigger any alarm or the help he felt he needed, rather those who replied merely confirmed that he had understood the issues. It appears that they had in fact normalised the situation which had developed over the years.

89. By the time that Mr Haynes took over the role in late 2017 during the MHPS investigation and during the three years leading up to the Inquiry, the combination of events and the increased investment in medical leadership, led to increased contact and support from the Medical Director. This is evident from the references to more conversations, meetings and correspondence during this time.

90. The absence of sufficient handover and induction, including training when taking on a new medical management role, featured in the experience of Mr Haynes who stated that there was an:

> "absence of an induction process or handover for incoming AMDs".[77]

91. The need for ongoing training specifically in relation to MHPS was emphasised by Dr McAllister who realised that the training that had been delivered was too ad hoc and stated:

---

75 TRA-02744, line 9
76 TRA-02811, lines 24-25
77 WIT-53952, paragraph 73.6

> "I think that for something as fundamental as MHPS and the Trust Guidelines, just to fire out guidelines and maybe to train one or two people misses the whole point."[78]

He went on to say that all doctors should have meaningful training to cover this important area when they start their jobs and this should be repeated every three years or so. This comment, reflecting the need for ongoing development, is a valid one.

92. Mr Mackle had been AMD for eight years at the time he retired. He referred to some management training during his 20 years in medical management roles but had little memory of it, indicating to the Inquiry that he had not been offered ongoing development.[79]

93. In summary, despite the fact that the AMD role is a key position in medical management and leadership, being responsible for the professional management of doctors in surgical specialties, advising on clinical standards as well as for developing strategic and operational plans for services, the lack of time, training, development and support led to difficulties in overseeing the range of their responsibilities. This resulted in a lack of attention to some of the key elements for which they were responsible. Clinical audit for example had 'collapsed'[80] and yet this was a key responsibility for the medical management line.[81] It is the medical management line who should have been leading any required improvements in this area, but the focus on quality and safety was not as clear as it should have been. Mr Mackle's comment that "quality was not overtly discarded"[82] reveals much about the culture and emphasis at that time.

78 TRA-02804, lines 21-24
79 TRA-02100
80 See paragraphs 360 and 361 of the Governance chapter
81 See job description at WIT-11836 to WIT-11840
82 TRA-02079, line 13

Medical management structure reporting to the Associate Medical Director

94. Each service or group of services was managed by a manager with the title of Head of Service assisted medically by a CL or CD as required. Consultant medical staff while supported by these service level medical managers, in reality relied on the HoS for day-to-day practical arrangements to support service delivery. Nursing support was provided as required.

95. In the urology service day-to-day operational matters were managed by the HOS. During most of the period leading up to the Inquiry this was Ms Martina Corrigan. She would routinely report through to the Acute Directorate via an Assistant Director but was responsible as far as possible for managing the service.

96. Ms Corrigan also had responsibility for Ear, Nose and Throat service and was very stretched. Ms Corrigan told the Inquiry that she would rely on the CL or CD to take forward any issues relating to medical staff whether this was related to conduct or to competence.[83]

97. All the medical and professional managers spoke of the very significant service pressures which impacted the time available for dealing with anything other than immediate problems.

98. It appears from the evidence to the Inquiry that, at service level, the general day to day management rested largely with the HOS and that many of the arrangements for dealing with issues and problems were ad hoc. Matters were dealt with outside of formal mechanisms so medical, nursing and professional managers did not come together to make decisions in a regular framework. This reliance on the HOS was referred to by Dr McAllister in his email of 2016 when he stated:

83 TRA-02980

> "Largely each specialty left to manage themselves, reliance on HoS to escalate issues."[84]

99. In her witness statement Ms Corrigan reflected on the accountability of medical management in the context of the urology service. She said:

> "In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. … It is my observation that there wasn't a clear line of accountability/management whilst I was in post. So, whilst the consultants were directly accountable to their Responsible Officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a Clinical Lead (Mr Michael Young), and whilst I believe it was understood that he should be managing the rest of the Urological consultants, Mr Young never had an actual job description outlining what this should entail and (from my recollection) only got 0.5 PA to be the Clinical Lead, so I don't believe that he ever felt that this was his role (although this would be a matter best addressed with him)."[85]

100. The CL in urology for much of the time relevant to the Inquiry was Mr Young. In the absence of a job description, he had his own definition of his role, calling himself on the one hand the "captain of the team"[86] but not seeing himself as having a greater managerial responsibility than his fellow consultants. He stated:

> "the Lead Clinician role is service-based and did not have a direct responsibility for other consultants other than a working relationship alongside them as colleagues on a daily basis and offering support and advice."[87]

He did not regard himself as responsible for managing and leading the service as a whole. He ought to have done so. He did organise rotas and meetings and

84 WIT-14875, point 5
85 WIT-26304, paragraph e
86 TRA-09044, lines 23-28
87 WIT-51780, paragraph 49.1

make efforts to gain consensus about key issues as required. He had been appointed in the early days of medical management, did not appear to have the benefit of ongoing development and training, did not have much time to devote to the role and was not given any objectives for the role. He was never challenged regarding his interpretation of the role.

101. The Medical Director at the time Mr Young was appointed was Dr Simpson (Medical Director 2009-2015). When giving oral evidence to the Inquiry he reflected that:

> "In a medical management structure, medical leadership structure, that's quite thin on the ground; well meant when it was first developed. But when that's thin on the ground, I think there's an awful lot expected of the lead clinician when they are trying to help. My view of the lead clinicians was that they're trying to help us. I wouldn't have been expecting too much of them. I also thought that we should be going easy on the lead clinicians because I wanted them to apply for clinical director posts; I wanted them as a sort of introduction to medical leadership."[88]

102. This statement reveals that, not only was there a lack of clarity regarding these roles but in some sense also a lack of expectation which was not energised over time in the way that it should have been. There should have been ongoing development of roles through appropriate training, discussion groups and mentoring opportunities. The Inquiry is surprised that individual medical managers did not themselves seek clarification of their roles and request additional time and personal development since the roles were clearly very challenging.

103. The Inquiry found the lack of support for medical management problematic. The responsibility for this situation rests with those tasked with developing and supporting effective medical management and leadership. It is principally the

88 TRA-09328, lines 9-19

duty of the Medical Director, with the Trust Board's overall insight and leadership to recognise the value of organisational development.

104. Each CL reported to a CD responsible for a group of services. These CDs did, in general, have job descriptions setting out a wide range of responsibilities. Four CDs had responsibility for urology in the period with which the Inquiry is primarily concerned. Mr Robin Brown, Ms Samantha Sloan, Mr Colin Weir and Mr Ted McNaboe. In common with AMDs, the CDs had relatively little time assigned to this role which was usually to be completed in around half a day per week.

105. Although they seemed to largely accept the situation, they were aware that to fulfil the expectations of the role more time was needed. Mr Weir (CD, 2016-2018) commented:

> "It is probably a role, if you are going to be strategically thinking, doing good governance, then you need a lot more time to it. [sic] You need a day a week perhaps to do it."[89]

106. The Inquiry understands from Dr O'Kane that more time for CDs and increased numbers of CDs has now been agreed:

> "I mean one of the things that we did do was to double the amount of time that the Clinical Directors had. So when I came into the Trust, the Clinical Directors had four hours a week, and in some of those cases that was to manage scores of doctors and to try to be cognisant of, you know, patient safety issues and any areas for development. So we increased the number of those and doubled the time that was given to each post." [90]

107. The responsibilities of CDs in Surgery did not in practice always appear to be clear either, even if they were articulated in job descriptions which made

89 TRA-02728, lines 19-22
90 TRA-11701, lines 19-27

reference to governance responsibilities. Mr Brown who was CD during most of the period 2008-2016 stated that:

> "The CD's role was mainly dealing with high, and often immediate priority, issues such as staffing, recruitment, rotas timetables, etc. Governance was part of it, but I would not have had in-depth knowledge, or total overview, of all the governance arrangements and issues in all of the six departments for which I had responsibility."[91]

He went on to say:

> "During that time my contribution to governance in Urology was mostly reactive, in that I addressed issues brought to my attention."[92]

He admitted that he did not have the time to be pro-actively involved and had little involvement with feedback from incidents or complaints. Despite the fact that he was working as a Urologist[93] he could not always attend meetings in urology and did not routinely attend meetings in other specialties either. This was largely due to the fact that the meetings would take place at the Craigavon Area Hospital while he was based at Daisy Hill Hospital.

108. Mr Weir who took over as CD in 2016 commented that although he would expect to be informed of issues:

> "the main elements of clinical governance (that is: quality assurance, education, clinic audit, research and development) were all organized by the specialty team of consultants under the direction of the lead consultant (Mr Young). I was fully aware that the events and activities were taking place

91 WIT-17524, paragraph 21.1
92 WIT-17525, paragraph 21.1
93 Mr Brown was appointed as a General Surgeon with an interest in Urology. Once consultant urologists were appointed, he reduced his urology work over time, although in 2016-17 he had a temporary contract as a Urologist. He participated in discussions regarding the development of urology and in Multidisciplinary Team meetings and he provided a basic urology service at Daisy Hill Hospital. He referred many patients to Craigavon Area Hospital as described at WIT-17524

and participated in joint audit meetings that encompassed all surgical specialties. I was therefore able to witness case presentations and morbidity and mortality reports by the urology team at such meetings. My oversight role was to be informed or appraised of patient safety matters that arose out of audit of activity or patient safety meetings."[94]

109. Mr Sam Hall was CD in Surgery (2010-16) but without responsibility for urology. He said that in terms of governance, responsibility lay with:

"mainly the AMDs and the medical director, with senior admin staff, who were involved. The process usually would start with an SAI or complaint, and be investigated. If action was needed it was at a higher level than me. Some would have been anonymised and discussed at audit meetings for learning."[95]

110. Mr McNaboe who took over from Mr Weir in 2018, did have responsibility for urology but felt that others were dealing with most of the problems. He described his role as:

"assisting with the job planning process, presenting any Urology SAI reports at the monthly governance meeting, dealing with all levels of staff educational and study leave, approving claims for waiting list and locum work. I also did some Consultant Appraisal work.
My role frequently overlapped with the work of the Associate Medical Director, Mr Haynes. As Mr Haynes was a Consultant Urologist issues relating to Urology tended to be brought directly to his attention rather than mine."[96]

111. Clinical Director roles were also frequently vacant, and some covered more than one hospital site. These factors would also have had a significant negative effect in terms of oversight and leadership.

94 WIT-19931, paragraph 86
95 WIT-40983, paragraph 45.1
96 WIT-15728, paragraph 8.3 and 8.4

112. Mr Brown commented on this saying:

> "the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated. So, I mean, the team in Daisy Hill, I was seeing them on a regular basis, I was meeting them in theatre, and so we were chatting about things in the tea room, but there were no tea-room conversations that I could have with the clinicians or the people in Craigavon. When I did meet with management, it was in an official meeting."[97]

113. In terms of the ability of CDs to discuss matters with operational and medical managers on a regular basis, Mr Weir commented that:

> "There was too much separation between clinical and operational management and there should have been regular team meetings of all concerned. These should have been minuted. …
> In retrospect, a much closer working relationship between senior operational and clinical managers was needed as well as better oversight by having all individuals involved, not just by frequent email."[98]

114. Mr Weir is not only drawing attention to the lack of structured meetings but also on the over reliance on individual conversations outside of meetings, in place of recorded actions arising from a properly run meeting. He is recognising, albeit with hindsight, the lack of clear pathways for escalation of concerns.

115. The issues of handover, induction, training and leadership are also reflected in Mr Weir's comments in relation to the period when he took over as CD in 2016. This was a significant period leading up to the formal MHPS investigation. Mr Weir commented that he did not receive any guidance or training for the post despite the fact that he assumed the role at a critical time for the issues in urology. He said:

---

97 TRA-09103, lines 7-16
98 WIT-19961, paragraph 158; WIT-19962, paragraph 160

> "I consider it a failure of good governance to ask a newly appointed Clinical Director with no previous experience to resolve, informally, a longstanding and complex problem with only a weekly meeting with my line manager."[99]

116. Mr Weir made a number of other observations based on his experience relating to the commencement of the MHPS process and the governance failings that emerged stating that:

> "Governance at the unit level would need better support with a governance lead appointed or someone with governance responsibility."[100]

117. As part of his commentary on the MHPS process he noted the following:

> "There was too much of a 'top down' approach, with one level dictating or asking the next level down to undertake a task or implement a policy. A team approach would, I believe, have helped monitor situations better and a horizontal management structure would have communicated and acted better in my view."[101]

This comment was sparked by his reflection on the events during his involvement at the start of the MHPS investigation and during the period up to his retirement in 2018 when, in his role as CD, he was made aware of ongoing issues concerning Mr O'Brien, about undictated clinics and large numbers of notes stored in Mr O'Brien's office.[102] At this stage he contacted Dr Khan, then interim Medical Director, by email,[103] as he had not been given any information in relation to the action plan which was implemented when Mr O'Brien was permitted to return to work following his exclusion. The situation was complicated by ongoing contacts with Mr O'Brien in relation to the MHPS investigation and

99 WIT-19934, paragraph 97
100 WIT-19962, paragraph 160
101 WIT-20014, paragraph 59
102 TRA-02709 to TRA-02711
103 TRU-258912

Mr Weir describes being uncomfortable at the idea of meeting with Mr O'Brien in relation to any of the MHPS issues without support.[104] He did attempt to agree a job plan with Mr O'Brien and had numerous conversations concerning this but was unable to obtain agreement. Mr Weir was on sick leave during the autumn of 2018 but nevertheless attempted to continue the job planning discussions and did have a number of conversations with Mr O'Brien about his pattern of work until he stepped down from the role at the end of the year.[105] There was clearly a certain lack of cohesion in the communication around the MHPS action plan and responsibility for it. It appears that Dr Khan did not act on the email from Mr Weir, nor did Mr Weir follow it up.

118. In summary, the CD role in the Trust, which is of central importance in the management of doctors, was a little disconnected from the individual services. It was largely reactive and consumed with what might be regarded as firefighting and the difficult task of job planning. There was insufficient emphasis on patient safety and clinical governance because responsibility for these matters appeared diffused, with no individual holding clear ownership. Moreover, there was an insufficient support structure for these. The Inquiry found that the CDs had useful reflections in their evidence to the Inquiry and had not been well served in terms of induction, handover, training and time allocation but there is no evidence that they had fully understood their duty as medical managers to be much more proactive in relation to patient safety issues. Importantly they should have escalated the fact that they did not have the resources to oversee this fully.

119. When giving oral evidence Mr Weir provided an important reflection when asked who should have sat down with Mr O'Brien to discuss the various issues in full. He said:

> "It could have been me, it could have been the Lead Consultant, it could have been the Associate Medical Director, it could be the Director of Acute Services and that's the problem. It just moves in all these different directions, and whose

104 TRA-02678 to TRA-02683; TRA-02721
105 TRA-02715 to TRA-02721

[sic] actually doing this. Then when it becomes so complicated and multi-layered does everybody else think, you know, who is ultimately responsible for doing this and to make those lines a little bit more explicit and clear, particularly when there's a complex investigation ongoing at the same time."[106]

120. Overall, it was clear that the doctors in CD roles experienced the same issues as the AMDs, with little allocated time, little handover, induction, training or development and with a large range of operational challenges. This was compounded by deficits in the governance structure and by some lack of clarity around responsibility and accountability across and between all the various management lines.

121. There were some occasions where the medical management structures in the Acute Directorate worked well in collaboration with the operational management teams under the Director of Acute Services. This was notable in the work that followed the proposals to restructure urology in Northern Ireland leading to the formation of Team South in 2009, as described in the Clinical Aspects chapter. There were weekly evening meetings involving the Urology consultants, the Urology CL, CD, AMD and the Director of Acute Services and this ultimately led to an increase in the numbers of urology consultants and new working patterns. There was good engagement with this process even though discussions were difficult.

122. There did not appear, however, to be a clear annual process to refresh strategy for future services that mirrored this approach in subsequent years. The urologists themselves did take proactive steps to develop their services and were particularly effective in for example developing nursing staff and developing the Thorndale Unit. In this sense the CL and consultant medical staff showed appropriate leadership at a unit level.

106 TRA-02729, lines 6-16

Other leadership roles in Urology

123. The Urology Department also carried a number of other medical management and leadership roles which were significant in terms of their importance and in terms of the time required. These included the Patient Safety Lead and the Multidisciplinary Team Lead. In addition, individual consultants took the lead in the development of aspects of the service as well as supporting various regional working groups. The GMC considers that all doctors have a role in management and leadership, and a well-functioning department recognises this and supports a team approach to covering the duties and responsibilities of doctors. The Inquiry recognises that the various management and leadership roles in the Trust's urology service had evolved over time and are continuing to evolve. Improved understanding and support for the broad leadership agenda for medical staff will however require continued improvement in line with the Trust's overall plans for organisational development.

124. Historically, there did not appear to be a clear sense of connection between the efforts to improve services at specialty level and the overall Trust senior medical management structures. Mr Anthony Glackin, who was appointed as a consultant in 2012, made the comment that from his perspective in the time leading up to the Inquiry:

> "the senior managers did not work well with Urology. Engagement with the department by the Clinical Directors, Medical Directors, Assistant Directors for Surgery and Directors for Acute Services was very limited and infrequent in my experience."[107]

This clearly indicates that there is a need for better connections between the service and the wider Trust.

125. The instigation of the Inquiry has led to significant work within the Trust to improve matters both in Urology and the Acute Directorate. The Inquiry has

[107] WIT-42307, paragraph 31.1

learned of very significant emphasis and investment in relation to the interface with Cancer Services, as well as leadership and governance generally. This has included a specific increased resource for medical management in urology through the appointment of Mr Haynes as a Divisional Medical Director for Urology Improvement in 2021.[108] However, it is clear that prior to these changes the consultants in urology did not feel a strong connection to the medical and operational SMTs.

The operation of medical management in Urology, Acute Directorate and the Trust with respect to the issues and concerns before the Inquiry

126. The consultants in urology and the medical managers in the Acute Directorate were committed to developing their services where possible and worked to deliver care. This was despite workforce shortages, operational challenges and financial constraints

127. When presented with a clear task the consultants and the operational and medical managers were able to work well together to frame strategic discussions and agree new ways of working. This is illustrated in the work done as part of the urology redesign which started in 2009 and was implemented in 2013, the response to this Inquiry, and more recently in response to the Getting it Right First Time (GIRFT) review in Northern Ireland.[109]

128. In the case of the various known concerns relating to the management of Mr O'Brien's difficulties with practice, the medical managers did not act

---

108 See job description at: WIT-54012 to WIT-54019

109 See the evidence of Mr Haynes at TRA-11501 to TRA-11507. The Getting It Right First Time (GIRFT) programme is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Northern Ireland Department of Health Elective and Cancer Services team to conduct a review of Urology across Northern Ireland using the GIRFT methodology. See the report at TRU-320188 to TRU-320238 and the GIRFT Action Plan at TRU-309783 to TRU-309806

effectively to support necessary changes in his practice over many years. This is described more fully elsewhere in this Report.[110]

129. Most of the operational managers were reluctant to directly tackle persistent behavioural issues in relation to a senior medical consultant, regarding this as a matter for the CL, CDs or AMDs or indeed the medical director. The medical managers were also themselves reluctant to take effective action.

130. The result of this was that the operational managers, as part of managing access to elective services were having to manage the issues. They were tracking delays in triage and at various times they were also focused on the problem of significant numbers of medical records being kept at home, long delays in dictation, absent dictation and backlogs of review appointments. The HOS escalated concerns about these issues to the Assistant Director and at times to the Director of Acute Services. These managers also attempted to ask Mr O'Brien to correct his behaviour in relation to each specific issue. At various points they raised the issue with clinical managers who then agreed to speak to Mr O'Brien. Repeated conversations took place in relation to these concerns over many years involving nearly all the clinical managers at some point including the CL, CD and AMD.

131. For the most part it appears that these conversations reminded Mr O'Brien that there was a problem and attempted to persuade him to change his ways. Things would then improve for a time before drifting back to old patterns. It was widely known that Mr O'Brien was idiosyncratic and did things 'differently' from other consultants, as is described in the Clinical Aspects chapter and that he struggled to perform his administrative tasks on time. The approach that was taken is best illustrated by the attempts to obtain adherence to the policies on triage described elsewhere in this Report.[111] There were a few occasions where more directive action was taken for a time, such as when in 2010 the Director of Acute Services Dr Rankin told Mr O'Brien that he could not take his planned study leave unless

110 See MHPS, Clinical Aspects and Governance chapters
111 See MHPS and Clinical Aspects chapters

he was up to date with triage, which was duly completed as requested.[112] Generally, the problem soon recurred and was in effect tolerated, and to some extent enabled by workarounds, that either asked other colleagues to do more, or changed systems to attempt to minimise risk as they saw it. This is discussed elsewhere in this Report. Indeed, Dr Rankin reflected that she also could have done more as referred to in the Governance chapter.

132. The full scale of all the issues was not fully appreciated by a single responsible person or group within the management structure. More significantly, no one appeared to appreciate the full risks to patient safety that might be lurking as part of a pattern of behaviour.

133. A key cause of the failure to realise the possible significance of some of the issues that were raised in relation to Mr O'Brien was the strong view that the failings were purely administrative in nature and did not give rise to patient risk. Further, there was a critical failure to understand his failings as a warning sign of a doctor in difficulty who might well be struggling with clinical issues. This view persisted until the MHPS investigation and following it until the time of the events triggering this Inquiry. The 'blindness' as to the full significance of these issues affected both operational and medical managers including the Medical Directors. On reflection and given the matters before the Inquiry, those interviewed acknowledged that the administrative issues alone were significant in terms of potential patient harm.

134. The issues were never tackled head on with any consistency and there was barely any formality at all in any meeting with Mr O'Brien until March 2016, by which time the issues had been recurring problems for many years. A series of issues were formally set out in a letter which was delivered in a face-to-face meeting as described in the MHPS chapter. This meeting was an important milestone in the lead up to the MHPS process.

112 WIT-15827, paragraph 30.2a

135. The Inquiry noted that even though some serious issues were not addressed, a number of specific clinical issues, where risk to patients was clear, were successfully resolved through the medical line management over the years. These are described more fully in the MHPS and Clinical Aspects chapters.

136. Such matters came to light in a variety of ways, but generally not directly through regular Trust governance processes, or through regular meetings at specialty level. Examples are described in more detail in the MHPS, Clinical Aspects and Governance chapters. In summary, the investigation of IV antibiotic use did not occur because of internal Trust clinical governance procedures; the investigation into cystectomy was also not sparked by any internal concern; and internal governance procedures did not detect the failure to follow guidelines for cancer treatment.

137. In all these situations, better clinical governance systems would have highlighted areas where there might have been a problem causing risks to patients. In the case of the IV antibiotic practice, investigations led to cause for concern and the practice was stopped. In the case of benign cystectomy, no conclusive aberrant practice was identified but cystectomy had in any case been transferred to the Belfast Trust, where a more specialist practice could be maintained. It is the case that the catalyst for this Inquiry was Mr Haynes' concern that patients had not been added to a waiting list and were at risk of delays to treatment. Ultimately this proved not to be accurate, but his suspicions brought about investigations which led to the discovery of a number of patients who had not received best practice treatment.

138. Once the Medical Director became aware of these potential risks to patient safety, a suitable process to investigate and address these matters was put in place.[113] This is described elsewhere in this Report. Clearly, where significant issues of safety and quality were identified and brought to the attention of the most senior medical manager in the Trust in a way that mandated action, there

113 See MHPS chapter and events that precipitated this Inquiry in the Clinical Aspects chapter

was an appetite for prioritising safety and quality, even though resolving matters was a laborious process.

139. Many witnesses recognised the need for improvement in internal governance systems as referenced earlier in this Report. Systems of governance failed to provide suitable alerts that might have highlighted matters sooner. There were no automatic and regular data feeds to the meetings which took place in the governance sphere and there were no mandated actions for all significant variations from agreed standards. If there had been robust well-resourced medical managers, they might have understood the need for these deficits to be addressed. They could have pressed for and led improvements in this important area of data and information, rather than adopting the passive approach which appeared to be the case for much of the period and across many of the issues with which this Inquiry is concerned.

140. Dr Wright as Medical Director, understood that there was a need to have a more proactive approach which could include, for example, a regular assessment of clinical outcomes and a better method for ensuring adherence to best practice standards.[114] Dr O'Kane and Mr Shane Devlin as Chief Executive Officers (CEOs) both understood that this would require improved support for governance and improved systems of assurance generally.[115] The need for this is referenced earlier in this Report.[116]

141. A key deficit in this area related to support for clinical audit as referred to in the Governance chapter. Medical managers with enough time and resource to focus on clinical quality issues in a more proactive way might have pushed harder for more support and resource in this area. We saw that Dr Khan, in his time as interim Medical Director, refreshed the clinical audit strategy in an attempt to

114 TRA-03269 to TRA-03276; WIT-17899
115 WIT-45184 to WIT-45186; WIT-00036 to WIT-00038
116 See paragraphs 116, 117, 118 and 259 of the Governance chapter

address deficits that had been identified through the Trust Internal Audit process.[117] More investment in clinical audit has been evident in recent years.[118]

142. There has also been a recognition of the importance of ensuring that clinical audit is linked more clearly to quality improvement. Witnesses to the Inquiry did not appear to have a clear view on the place of quality improvement within Trust processes as is discussed in the Governance chapter.

143. The improvements in tracking, audit and strategic focus in relation to cancer that have taken place since the Inquiry started have been welcomed by staff. More is said about this in the section on Serious Adverse Incidents in the Governance chapter. The Trust has encouraged this and has allocated increased resource by investing in additional posts. Notably the Trust also appointed an AMD to oversee improvements in urology (Mr Haynes). This medical management leadership input was critically required and has undoubtedly been of value.

144. The Inquiry was surprised to learn that until its work started, no one in the Trust had fully appreciated the patient harm resulting from a failure to adhere to and monitor best practice standards for cancer care. This situation was compounded by disconnected relationships between urology (and other surgical services) with Cancer Services. As referred to previously,[119] Cancer Services presided over numbers and departmental targets for access as they were required to do but did not see their role as overseeing standards of care in cancer more generally, including those set out as part of Cancer Peer Review Standards,[120] or defined by the Northern Ireland Cancer Network.

145. From the evidence before the Inquiry, it appears that the cancer leadership team did not appreciate the need to provide the necessary challenge to individual cancer services and their MDTs, to coordinate the strategic development of services for patients with cancer or to link in with Board committees. The Board

117 WIT-31485 to WIT-31505
118 See Governance chapter, paragraphs 158, 238 and 359
119 See Clinical Aspects chapter, paragraphs 134, 206, 207, 232, 257 and 277
120 See Clinical Aspects chapter, paragraphs 201 and 425

was not provided with, nor did they ask for, a suitable overview of cancer even though this is such a critical part of the Trust's services. This is another area where strong medical leadership at every level and particularly for Cancer Services might have made a significant difference.

146. The Inquiry noted the recommendations made by Dr Dermot Hughes, Chair of the nine SAIs, that the medical leadership roles in Cancer Services should be reviewed.[121] He was clearly of the view that there was a deficit in leadership in Cancer Services. The Inquiry noted that the Head of Cancer Services reported to the Director of Acute Services via the Assistant Director of Cancer and Clinical Services and that the job description included reference to the development of strategy and provision of a high-quality service. However there was no specific reference to the need for any ongoing quality standards to be reported or to the need for Peer Review Standards to be re-examined at regular intervals.[122]

147. Cancer services received medical input from an AMD for Cancer and Clinical Services[123] and a CD for Cancer Services. The job descriptions for these roles[124] emphasised a role predominantly concerned with the management of medical staff but also refer to working with the various operational directors to assure high quality care. The CD role relates to oncology, palliative care and the chemotherapy unit only. The full scope of the Divisional Medical Director in terms of links to the other directorates that treat cancer patients is not clarified. The revised job descriptions in 2024[125] have a stronger emphasis on quality and are a little clearer but there does not seem to be an articulation of a clear overarching medical role that has an input into a Trust-wide strategic direction that covers all the aspects of cancer care across all the directorates.

148. The Inquiry considers that a Divisional Director for Cancer Services should have a formal remit to consider strategic development of cancer care across the Trust. The Inquiry recommends that the medical management role for Cancer Services

121 WIT-85193
122 TRU-02587 to TRU-02593
123 Clinical services in this context refers to radiology, pharmacy and pathology laboratory services
124 TRU-02254 to TRU-02261; TRU-162786 to TRU-162789
125 TRU-305887 to TRU-305891; TRU-305894 to TRU-305898

be strengthened and supported and directed to fully embed the learning from this Inquiry. It must set a firm strategic direction for the management of patients with cancer.

149. A significant clinical issue arose in 2015 relating to the use of glycine for certain procedures. Mr O'Brien did not comply with the Trust (and indeed regional) policy. This lack of compliance was not identified or challenged by way of any Trust management mechanism. This is also referred to in the Clinical Aspects chapter.

150. In 2015, a directive was issued from the coroner's office, via the Chief Medical Officer (CMO) in Northern Ireland, to Medical Directors regarding the potential hazards associated with the use of glycine as an irrigating fluid during surgical procedures. The communication highlighted the risk of serious harm, particularly during Transurethral Prostatectomy due to hyponatraemia, which can occur during prolonged operations involving glycine irrigation. This risk was underscored by a patient fatality following gynaecological surgery where severe hyponatraemia occurred due to glycine use. Evidence indicated that this risk could be mitigated by substituting saline solution for glycine in certain procedures, including prostatectomy. Accordingly, a regional initiative was adopted, and Trusts were requested to support this approach and provide updates on implementation progress.

151. There was considerable work done in this area with good engagement from all the urologists and effective leadership from the CL, Mr Young and others, as well as appropriate reporting at the Acute Directorate Governance meeting. The directorate supported a bid to obtain new equipment to allow the necessary change in technique. The Trust agreed a new policy avoiding the use of glycine in routine prostatectomy as indicated by Mr Young in an email dated 16 November 2017, where he states:

"Urologists in the department will be maintaining their position for a switch to using saline to perform TURP as of 1st January 2018."[126]

In this instance, presented with a clear task, the medical managers and consultants worked well together to establish the new policy.

152. Mr O'Brien continued to use monopolar resection with glycine and maintained the position which he had communicated via email in March 2016 that he would "not use or try bipolar resection again."[127]

153. This lack of compliance was not formally detected and therefore it was not effectively managed through medical management structures, nor was any proactive audit of compliance with the new policy put in place. There seemed to have been a lack of understanding amongst medical managers in urology and the Acute Directorate regarding how to use basic management processes, including audit, to best effect when needed. It would have been sensible to ensure appropriate audit of this new policy in view of Mr O'Brien's earlier comments. Mr Haynes in oral evidence later reflected that, being aware of this situation, he should have prompted a wider look at Mr O'Brien's practice at the time of the MHPS investigation. The Inquiry agrees and is of the view that Mr Young as CL should have raised this issue as a patient safety risk as he was clearly aware of Mr O'Brien's views. Although the Inquiry considers that the CL roles had not been properly defined and appropriate development was not in place, Mr Young had a duty to seek clarification and development regarding the role that he took on for so many years.

154. Some of the concerns that were raised in relation to the practice of Mr O'Brien were simply a failure to comply with Trust policies or directives. There appeared to be relatively little attempt to seriously intervene using the medical management hierarchy and available tools of management. The evidence before

126 WIT-103698, paragraph 6
127 TRU-395978

the Inquiry suggests that these issues were largely confined to the practice of Mr O'Brien although formal data on this is lacking.

155. This included for example, the way Mr O'Brien conducted his private practice. Mr Haynes raised concerns because he was worried that private patients were being unfairly prioritised above health service patients.[128] He regarded this as both a moral issue and a patient safety issue. This was not fully investigated even at the time of the MHPS investigation.

156. The Inquiry saw no evidence of any attempts to inquire about, or assess compliance with, the Trust's private practice procedures. These were not effectively monitored. Moreover, a first step reasonable management instruction to urge compliance was not issued. Retrospective audit reports in this area were produced via Internal Audit[129] and these confirmed poor compliance in this area generally. Various improvement actions were agreed following these audits. The way Mr O'Brien conducted his private practice was however in some ways idiosyncratic, involving irregular interfaces with the Health Service. For example, unlike most consultants, Mr O'Brien's private patients were not operated on in private hospitals, but in Trust facilities apparently as health service patients. Despite this, his practice was not the subject of any enquiries or scrutiny from medical or professional managers. Nor was it discussed in appraisal.

157. Another issue related to the scheduling of patients for surgery, where there were problems in persuading Mr O'Brien to adopt the procedures accepted by his colleagues to indicate the urgency of patients, so that the most urgent patients would be prioritised for treatment. This was described by Mr Ronan Carroll in his witness statement to the MHPS investigation where he states:

> "Mr O'Brien has no clinical priority noted on the theatre list. He said they are all urgent and 'they will be done'. We need to be able to prioritise patients

128 See MHPS, Clinical Aspects and Governance chapters
129 WIT-11631 to WIT-11656

> 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."[130]

Mr O'Brien insisted on controlling the scheduling of patients himself. Attempts to standardise procedures were hampered because he declined the assistance that would have streamlined the procedure and ensured equity. This was a further cause for concern as discussed by Dr Rankin in her witness statement.[131]

158. A robust medical management at service level, supported by operational managers with open discussion of these issues in joint meetings and the use of procedures for escalating concerns would have addressed these issues.

159. There also appeared to be a reluctance to escalate issues to the Medical Director even when this was suggested[132] and little consideration of referral to NCAS, even when this had been suggested in a meeting including the Medical Director and Chief Executive. More is said about this in the MHPS and Governance chapters.

160. Part of this was probably related to the fact that there was apparently no insight from CDs or AMDs that this pattern of behaviour indicated that this might be a doctor in difficulty in need of help and assistance. Certainly, there was not enough awareness of the possibility of external support using what is now the Practitioner Performance Advice (PPA) arm of NHS Resolution (previously NCAS). Dr Wright in his evidence commented on the need for development of medical managers in this area, (see above). Mr Brown intuitively had an appropriate approach when he stated in an email to Ms Trouton:

> "Aidan is an excellent surgeon and I'd be more than happy to be his patient…so I would prefer the approach to be "How can we help"."[133]

130 TRU-00765, paragraph 24
131 WIT-15870 to WIT-15872; WIT-15909; WIT-15912
132 See Governance chapter, paragraphs 373 and 393 (ref Mrs Burns under urology governance)
133 WIT-17687

This was not however followed through with any offer to help.

161. Ensuring that doctors in difficulty can access appropriate help is a complex area and one which requires considerable experience as well as expertise. This is often problematic and for this reason a clear programme to ensure senior medical managers can discuss approaches has to be an important part of ongoing development for medical managers and leaders. Support for doctors in difficulty must be tailored to each individual doctor. It may need to be confidential, but pragmatically a senior group of medical managers meeting to discuss individual doctors and agree how to deal with the issue has to be a very important component. Trusts should be able to tailor approaches, using external help if necessary, to devise a programme of work with the agreement of the doctor and the clinical service. This could include for example retraining, psychological support, administrative assistance to improve processes or even an agreed reallocation of duties. When Mr Brown articulated 'how can we help' this should have prompted a medical management discussion aimed at remediating the problem.

162. There were a number of occasions when it appears that medical managers were reluctant to confront issues in face-to-face meetings. This should be a normal part of day-to-day medical and operational management. We saw this when Mr Mackle and Ms Corrigan met with Mr O'Brien in 2016 to give him a letter specifying four areas of concern regarding his practice.[134] The letter was delivered in a very short meeting and was the start of a sequence of events leading up to the MHPS investigation. The meeting was not structured in a way that allowed full exploration of the issues with agreed actions to follow. During the months that followed no one saw fit to meet with Mr O'Brien to agree any plan of action or inform him of the discussions underway. He himself did not seek help, support or clarification.

134 See paragraph 160 of the MHPS chapter, where the concerns are set out

163. The way this meeting, the lead up to it and actions following it were conducted, indicates a failure of medical management at each level in the Trust. It is also notable that no human resource support was sought and that much of the input into the letter constructed came from the HOS, rather than from Mr Mackle or Mr Brown as the senior medical managers covering urology. The Medical Director, Dr Wright, who had advised the approach in January 2016 notably did not seek to follow up regarding his advice until almost nine months later.

164. In the Autumn of 2016, leading up to the MHPS investigation, there again seemed to be a reluctance for medical managers to confront Mr O'Brien directly and indeed he knew nothing about the various discussions taking place until he was excluded from the Trust on December 30, 2016. During this period Dr McAllister stood down as AMD, there was a new CD (Mr Weir) and there was inconsistent decision making and communication as described in the MHPS chapter. All these factors seemed to disperse responsibility. Nevertheless, given the seriousness of the concerns raised, someone should have spoken directly to Mr O'Brien to listen to his views and inform him of the discussions underway. When Mr Haynes took over as AMD a year later, he also did not speak to Mr O'Brien directly in relation to the issues which, by this time, were under investigation in the MHPS process. In his role as AMD he should have actively engaged with Mr O'Brien on a regular basis to ask him if he needed support.

165. The reason for this lack of face-to-face challenge seemed to have a number of origins. The Inquiry recognises that it may have been difficult for Mr Haynes in his new role, as he was a colleague who had raised issues regarding aspects of Mr O'Brien's practice in the MHPS investigation. Mr Haynes articulated his own reflections on his lack of direct challenge to Mr O'Brien during his time as AMD stating:

> "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. …

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."[135]

Notably the CD at that time was Mr McNaboe who stated that he thought Mr Haynes was addressing the issues (see above) and therefore did not get involved.

166. Mr Glackin commented on a lack of face-to-face meetings between urology consultants and senior medical managers at the time of Mr O'Brien's exclusion. He indicated that the consultant team had not been fully appraised of safety issues in the department and would have valued a discussion with the Medical Director at this time. The Inquiry agrees that input from the Medical Director would have been of benefit to the team in these circumstances.

167. The Inquiry is of the view that this lack of face-to-face discussion was unhelpful and would be the opposite of what, for example, a 'restorative just culture' approach as pioneered in Merseyside (Mersey Health Care Restorative and Learning Culture 2016) would recommend. Ms Vivienne Toal spoke of this in her

135 TRA-00841, line 28 to TRA-00842, line 18; TRA-00843, lines 7-15

comments on the change the Trust is planning to put in place and the ongoing work on culture.[136] Dr O'Kane and Ms Eileen Mullan also gave views on the importance of culture.[137]

168. In addition to the statements made by the Medical Directors, Dr Wright and Dr O'Kane, other medical and professional managers who gave evidence commented on the respect in which Mr O'Brien was held as a senior consultant and his relationship with the Chair of the Trust. This included the rumour referred to by Mr Haynes that Mr Mackle had allegedly been accused of bullying by Mr O'Brien. They, like Mr Haynes, also commented on his legal connections.[138] It is not clear exactly what impact this had but it should not have been allowed to impact on the management and leadership responsibilities of the managers whether operational or medical. They should have had patient safety as their prime concern. Mr Hayne's expression that Mr O'Brien was "a challenge to challenge",[139] born out of experience over years, covers the general feeling that seemingly explains at least part of the unwillingness of managers to enter discussions with Mr O'Brien.

Difficult doctors

169. Dealing with problems relating to doctors in difficulty and difficult doctors is an essential part of the professional management responsibility of all medical managers. The approach to this should be led by the Medical Director assisted by HR. There should be an effective support structure which includes ongoing training and development. All doctors have a duty to understand this and to raise issues relating to colleagues when this impacts on patient safety.[140]

170. Evidence from each of the Medical Directors – Dr Wright, Dr Khan and Dr O'Kane indicated that they understood this responsibility, were aware of deficits and were

136 TRA-03494 to TRA-03495
137 WIT-45168 to WIT-45169; WIT-100557 to WIT-100558
138 See evidence of Ms Corrigan at WIT-26224, Ms Hynds at TRA-03773 and Dr Chada at TRA-03666
139 TRA-00842, lines 1-2
140 See GMP, Domain 2 at INQ-30878 to INQ-30880

making efforts to improve matters with gradual improvements planned and delivered since the Inquiry started. Dr O'Kane told us about these in her evidence and the efforts are referred to at various points in this chapter. Changes included an emphasis on more open and inclusive regular discussions amongst divisional medical directors with respect to, for example, Medical Appraisal.[141]

171. Procedures for dealing with concerns relating to medical staff in difficulty were acknowledged not to be as clear and embedded as they should have been. The procedure for managing concerns relating to doctors did exist within the medical leadership structures and support for difficult issues could be and was provided by HR. This support was not always accessed as, for example, was the case in March 2016.[142] If there had been a greater awareness of the procedure and had good human resource support been utilised from the point of discussion with the Medical Director, subsequent difficulties might have been avoided. Mr Mackle acknowledged that he did not have enough training or experience in this area. This incomplete understanding extended to other medical managers.

172. The poor understanding of Trust policies, the MHPS framework and of the possibility to utilise the advice of NHS Resolution[143] were barriers to the effective management of concerns generally. Even senior experienced medical managers did not have as clear an understanding of these matters as might be expected and operational managers had not received any specific training in this area. The impact of this was a lack of understanding about how to deal with concerns quickly and without resorting to more formal, lengthy procedures before patterns of behaviour became entrenched (see comments by Dr Wright earlier in this chapter). Because of this lack of understanding there was an over reliance on very informal and ineffective conversations when, as Dr Wright reflected, early intervention would have been better.

141 TRA-11716 to TRA-11717
142 See above and MHPS chapter
143 NCAS became PPA and subsequently part of NHS Resolution in 2013

173. The Trust has done quite a substantial amount of work in developing an understanding in relation to managing concerns about medical practitioners since the Inquiry began. An example of the new approach is the workshop run by Ms Zoë Parks – Head of Medical HR entitled 'Handling Concerns about a Doctor or Dentist'. This workshop includes an explanation of the concept of 'restorative justice' as well as information concerning a 'Medical HR Doctors in Difficulty Hub' providing links to a range of resources. This is a difficult area and one for which there is not necessarily a single simple way to understand procedure. The Trust has, therefore, usefully signposted managers to the resources provided by NHS England, NHS Employers, NHS Resolution, Mersey Care Restorative Just and Learning Culture, as well as the appropriate Trust Policies. The Trust has specifically recognised the need for a better understanding regarding the use of all relevant policies, by providing training for both clinical staff and processional managers and Board members. The use of case studies in this workshop and links to HR advisors also emphasises the need for discussion when these matters arise.[144]

174. At the time the MHPS investigation was commenced the Trust had a process which operated through an Oversight Committee. That policy states that in relation to a specific issue about medical staff:

> "The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns."[145]

175. This principle of having such a group to oversee difficult procedures is clearly sound, however the operation of this group in terms of the issues relating to Mr O'Brien seemed to be rather confused in a number of ways. Effectively, it was

144 TRU-306133 to TRU-306156, Workshop 2023
145 TRU-83688 to TRU-83689, paragraph 2.5

used as a decision-making forum and not purely for assurance as it was designed and it did not follow its own terms of reference. Moreover, the clinical input was insufficient and there appeared to be some lack of transparency surrounding the deliberations of this meeting with little knowledge amongst medical managers in terms of how it operated. Certainly, one of the divisional medical directors articulated concerns. Dr McAllister in oral evidence admitted that he did not really understand the purpose of the meeting and as divisional director was not involved. He considered this inappropriate.[146] Dr Chada who was herself a divisional director, was not supplied with the minutes of the Oversight meetings leading up to her investigation and was uncertain as to the actual sequence of decisions.[147]

176. Dr O'Kane described seeing the need to improve this situation, so she set up a Doctors and Dentists Oversight Group which she described as:

> "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."[148]

177. This new approach is designed to allow greater sharing of ideas, through interactive dialogue. This is an important part of establishing a fairer and more restorative culture as well as improving decision making for medical managers. Medical managers need to be able to have meaningful conversations with each other and with the Medical Director in the spirit of mutual understanding. Similarly, doctors in difficulty need to be able to have direct conversations with their medical managers and, where indicated, with the Medical Director. The Inquiry noted that there were very few direct conversations between Mr O'Brien and his more senior medical managers. He never met with Dr O'Kane, despite

146 TRA-02815 to TRA-02816
147 TRA-03599 to TRA-03602
148 TRA-01578, lines 23-29; Terms of Reference for same are at WIT-47266 to WIT-47269

the fact that she reported him to the GMC. The Inquiry considers that meetings between individual doctors and medical managers continue to have an important role in establishing effective communication and trust. It is difficult to understand why Dr O'Kane and others did not take the time to meet with Mr O'Brien or his CL, Mr Young and listen to their views. Dr O'Kane acknowledged that she should have taken the time to do this.[149]

178. The very poor way in which the Trust dealt with the actions recommended as a result of the MHPS Investigation, as discussed in the MHPS chapter, is a good illustration of the difficulties present in the Trust in terms of the connections between operational and medical management, including the hierarchy of medical management. It also reveals poor oversight from the Trust Board; the confused operation of the Oversight Committee; a lack of robust well understood data for use as a tool for improvement; a lack of clarity regarding medical management roles; difficulties with job planning and appraisal; and a culture that allowed hierarchy and a degree of secrecy.

179. The arrangements for the monitoring of Mr O'Brien's practice which were established at the beginning of the MHPS investigation in February 2017 to allow him to return to work without compromising patients, depended on the HOS reporting to Dr Khan any breaches of standards set for Mr O'Brien in relation to triage, dictation, storage of notes and the management of private patients. The standards on which he was measured were not in general use and were laborious to measure. The AMD, CD, and CL were not aware of the exact details of the action plan agreed at that time. Following the MHPS determination, there was poor understanding of who should own the actions and Mr O'Brien's grievance was allowed to derail important actions. This was further confused by the turnover of key senior staff including the Medical Director and the Director of Acute Services. Accordingly, the recommended formulation of a new action plan with input from PPA did not materialise. The recommended job plan review started but was not finalised and there was no enhanced appraisal planned. The full review of management in the Acute Directorate never took place and instead

149 TRA-01471

a poorly thought out and inadequate review of clerical processes was done some two years later. This last problem seems partly due to the use of the term 'administrative' in Dr Khan's determination which is used in some countries to refer to management. However, as his comments related to 'failure of management' any full consideration of the report would have understood his meaning. The Board were not appraised of the seriousness of his findings, and if they had been then this part of the recommendations is likely to have been followed through more effectively.

180. The new approach instigated by Dr O'Kane to replace the Oversight Group was designed to allow much more sharing of methods, better oversight and assurance and should in effect provide ongoing development of senior staff. This should also improve the problems relating to the parallel lines of management evident between operational and medical staff that seemed to have led to a failure to share both perspectives and resource. Effective management at each level should include a joint operational and medical management approach. It also requires a shared understanding of what to do in difficult situations, including how to manage behaviours when simple conversations and solutions fail. There needs to be widespread knowledge of what support can be accessed from HR or other support services and from the senior medical managers. This could include support for the staff managing concerns and support for the doctors causing concern.

Serious incident management in relation to medical management

181. The approach to effective serious incident management, which must include learning from error and the actions which must be put in place following an incident, is often a key point of reference for medical staff and for medical leaders. There may be high profile cases of significant patient harm and there are always translatable lessons across specialties. It is also an area where strong medical leadership from the Medical Director can assist in supporting processes and engaging doctors in leading improvements.

182. Although there was a regular assessment of potentially adverse incidents in the Acute Directorate, and considerable time and effort was expended in the classification of incidents, the range of medical staff involved in decisions was relatively narrow. This was problematic as there were delays in timescales for decisions that would confirm the severity of the incident due to absence of key medical staff. Wider engagement of a broader group of medical staff, not necessarily all in formal medical management roles, in all aspects of incident management with stronger medical leadership at a Trust wide level would probably improve the detection and learning from harm or possible harm. This is discussed more fully in the Governance chapter in the section on SAIs.

183. Most staff and especially clinical staff regard patient safety as an essential overarching responsibility and would assume that everyone understands what this means. However, in order to ensure that everyone is clear about what patient safety actually means and to explain decision making concerning, for example, serious incidents, the concept needs to be at the heart of all Trust meetings, especially governance and patient safety meetings. The evidence the Inquiry heard clearly showed that doctors and other staff were often not aware what action had been taken following incident reporting. Moreover, even if serious incidents were discussed in a patient safety meeting for example, doctors could not clearly articulate who had to take forward any necessary actions. This is discussed further in the Serious Incident section of the Governance chapter.

184. In urology, for example, there had been a number of serious incidents relating to urological stents. These had often been inserted in an emergency but were left in for too long causing complications. Although the issues were discussed and possible remedies considered, it remained unclear as to who was to lead the practical improvements in processes needed to address the problem. None of the medical managers involved seemed to think this fell precisely within the scope of their leadership duties. This particularly serious problem of in-dwelling stents recurred many times over a period of years. The Inquiry recognises that so called ‘forgotten stents’ is nationally, and indeed internationally, recognised as a problem but in the case of the Trust there was too little focus on devising a

clear action plan to resolve the issue. This is a situation where one would have expected Mr Young as CL to step in to oversee a plan of action or to allocate that duty to another clinician.

185. The management of serious adverse incidents and governance systems was recognised as in need of improvement. However, the Inquiry considers that the medical leadership duty in this area was not as clear as it should have been. We recommend that in future there needs to be a key programme to ensure, as far as possible, serious incident action plans should have a clear medical lead and there should be a requirement to account for delivery of the relevant action plan. In the specific case of urology stents there should be a system where stents are scheduled for removal at the time when they are inserted. Where there is to be a delay patients should be quickly rescheduled. It is important that such a system is overseen by medical leadership, probably at a higher than service level.

186. Dr O'Kane as Medical Director realised that:

> "it all seemed to be dealt with in silos down through the different Directorates but not shared or given oversight by the Medical Director"[150]

and Dr Hughes commented on the value of oversight in these areas.[151]

187. Lack of oversight in incident reporting and handling presents a risk to effective leadership of the quality and safety agenda from the senior clinician in the organisation. This has been improved following recent work which has recognised the need for corporate oversight and dissemination of learning from serious incidents which are now discussed at the weekly SMT Governance meeting and is important in terms of medical engagement and medical leadership more generally. More is said about this in the Governance chapter.

150 TRA-01494, lines 8-11
151 TRA-01020 to TRA-01021

188. The various improvements made in oversight and medical involvement at each level should in time assist with ensuring that clarity of roles and responsibility for action is clearer. This is particularly so for the medical management line and specifically in terms of the learning and improvement actions following serious incidents

189. The Inquiry was surprised that neither the CL in urology, Mr Young, nor the Patient Safety Lead, Mr Glackin, saw themselves as in charge of ensuring that, whatever necessary changes were required after serious incidents, were implemented in urology. The action plans after serious incidents were delegated to the directorate and then to the relevant service, but there was poor tracking of the necessary improvement actions which were not necessarily specifically delegated. This, together with operational pressures and unclear senior leadership in this important area was probably a reason for the lack of clarity regarding responsibility for action. More is said about this in the Serious Incidents section of the Governance chapter.

190. The Inquiry considers that the prevailing culture in the Trust and certainly in Urology and the Acute Directorate included an excessive and unhealthy deference to doctors and especially to senior doctors. This was coupled with an unwillingness to confront colleagues so that the medical managers did not tackle issues relating to Mr O'Brien appropriately.

191. The Inquiry noted the evidence of Dr Hughes regarding the difficulty doctors had in challenging their colleagues and agrees that this was partly the result of the tight knit social structures in Northern Ireland. Most doctors had trained together and knew each other well.[152] This feature of Northern Ireland's medical fraternity was also recognised by the Independent Neurology Inquiry in its report.[153] A further difficulty related to the rotation of medical managers back into the clinical workforce. This is a recognised problem in medical management generally. Another factor was the lack of overall focus on building a safety culture. In

152 TRA-01976 to TRA-01977
153 INQ-10750 to INQ-10753

addition, on a day-to-day basis, medical managers were simply fearful of causing upset with their colleagues who they relied on to deliver care for their own patients. In a situation where there are huge pressures on delivery of service and difficulties with recruitment and retention such as in this Trust, there is an even greater inclination not to cause upset.

192. Another cultural problem related to some difficulty in what might be regarded as a managerial/clinician disconnect which may have been present in some parts of the Trust. This is a recurring theme in discussions relating to medical management and leadership in the NHS. Although the importance of engaging and involving doctors in a way which optimises the way doctors and managers work together is well understood, it is also well recognised that doctors often feel disconnected from managers. This presents a risk to effective leadership and hence to patient safety. Dr Wright clearly recognised the dangers of a disconnect between consultant medical staff and the Trust management team. During his time as Medical Director, he was trying to re-energise some joint purpose within the senior medical management teams.[154]

193. It was clear from Mr O'Brien's oral evidence to the Inquiry that he had a mistrust of doctors who took on managerial roles[155] and did not think he should be 'managed'. He also stated that he preferred the 'old' method of going personally to the Chief Executive Officer each year with a list of requests. It was clear that he had little faith in medical management generally.

194. Further, he confessed to having had little understanding of the incident reporting system – he had suggested, albeit jokingly, that the incident reporting paperwork – known as an IR1 related to a tax return.[156] This reveals a considerable lack of understanding of governance and management systems and a lack of what is known as 'engagement' with the overall Trust. Mr O'Brien did not see himself as "the Trust".[157]

154 See above, paragraphs 45 to 48
155 TRA-05010 to TRA-05012
156 TRA-04736; See also the Clinical Aspects chapter, paragraph 120
157 TRA-05010 to TRA-05011

195. Mr O'Brien was not alone in his sense of disconnect from the Trust; other clinicians such as Mr Glackin also felt little connection with the medical management structure.[158]

196. There can often be a tension between 'the Trust' and individual doctors and this is more likely where medical management is not as effective as it needs to be. This came out in evidence to the Inquiry when the urologists discussed triage and Mr Glackin reflected that the consultants could not agree, quoting specifically that:

> "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. … 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."[159]

197. Evidently some of the consultants were of the view that the Trust should take responsibility and tell the doctors what to do regarding triage, but at the same time there was a tolerance amongst them of doctors doing their own thing and not following policies. Mr O'Brien was in effect allowed to do things differently from others as the view was "that's just Aidan".[160]

198. The Inquiry considers that, although it is a doctor's personal responsibility to be aware of Trust systems and policies and comply with them, as is indicated by the GMC,[161] it is nonetheless important that systems work in a way that makes sense to staff. There needs to be a sense of all staff working together for an agreed aim and this has to be embedded in the way everyone works.

158 See paragraph 124 above
159 TRA-08798, line 26 to TRA-08799, line 6
160 WIT-103608, paragraph 3.4
161 See GMC Professional standards, Leadership and management at: INQ-30846 to INQ-30866

199. The Inquiry saw a lack of medical engagement with the overall organisation present in urology. This suggests there is a need for a stronger, better supported medical management team that sets out a clearer vision of the primacy of patient safety. This should be led by the Medical Director's office and supported by each tier of management.

200. One of the big challenges faced by medical managers and leaders is their duty to help all doctors and indeed all staff to understand that they are in fact 'the Trust'. The Nuffield Trust issued a paper summarising some of these issues in the context of the 'doctor manager divide'.[162] It refers to this as an ongoing challenge in the NHS generally.

201. The Inquiry had a strong sense that operational pressures dominated the landscape in urology and in many other departments and this led to pressure on medical staff to perform additional duties such as extra operating lists and waiting list initiatives. Their energy and time was diverted to trying to alleviate the waiting lists. This had the unintended consequence that there was, at times, relative disengagement from anything beyond this. Doctors and managers both spoke of the extraordinary efforts to meet ministerial targets to allow the Trust to succeed in this area and they also spoke of the Health and Social Care Board (HSCB) applying external pressure to meet these targets. There appeared to be more reference to the HSCB than there was to the Trust Board, seemingly because the HSCB distributed additional funding. The perception of doctors and managers was that patient safety or quality of care was not sufficiently prioritised by the Trust Board, as most energy was devoted to achieving ministerial targets, which were directly monitored by the HSCB under their statutory duty to do so. No one spoke of any emphasis on supporting an overstretched workforce. The Inquiry did not interpret these perceptions as an overt dismissal of quality issues by the HSCB or the Trust Board, but rather as an indication of the lack of a clear overarching mandate to focus on patient safety.

---

162 See: Nuffield Trust. Powell, A., Davies, H. (2016) "Doctors and managers: a narrative literature review". At: https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/doctors-managers-lit-review-web-final.pdf

202. In terms of culture therefore, there was an insufficiently clear overall Trust vision and focus that emphasised the central importance of patient safety or supported all that is required to foster a safety culture focused on learning and improvement. This was not a deliberate omission, but it had a negative effect on medical and staff engagement generally, effective medical management and leadership and posed a risk to patient safety.

203. The responsibility for supporting the culture and structures needed to achieve improvements in clarity of vision and effective clinical and medical management rested with the Medical Director, the SMT and the Trust Board**.** Strong medical management and leadership may have succeeded in better development of the focus on safety and quality and safety culture if there had been increased medical representation on the Board.

204. Dr O'Kane when describing the improvements underway stated that:

> "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".[163]

By acknowledging the need for clarity in this area as part of the required cultural reform work, she effectively supports the views of managers and medical staff who spoke of the focus on ministerial targets and the large amount of time and attention spent trying to achieve them. It corroborates the view formed by the Inquiry that focus on quality and safety was reduced as a result.

[163] TRA-11609, lines 16-22

205. According to ERG minutes, Dr O'Kane, in a presentation to the Trust Board in September 2023,[164] spoke of the need to clarify the vision, values and strategy for the Trust with staff, in terms of culture and leadership.

206. The detailed minutes of the ERG recorded that Dr O'Kane informed the Trust Board that discussions had taken place between the SMT. They state:

> "The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top-down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust."[165]

207. This led to a commitment from the Board to draft a new Organisational Vision for the Trust that would be underpinned by a new five-year Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately.

208. As described in these meeting notes, Dr O'Kane had emphasised the need to commit leadership to co-produce the Vision and Strategy by involving all stakeholders and specifically recorded that:

> "in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
> - Safe and Quality Care
> - Investing our resources where they add most value
> - A commitment to following through all actions that are agreed
> - All underpinned by intelligent use of data."[166]

164 TRU-303678 to TRU-303720
165 TRU-303681 to TRU-303682
166 TRU-303682 to TRU-303683

209. The need for a programme of organisational development to assist staff to understand the importance of all the elements of a new organisational vision and strategy, one embodying the principles of psychological safety and learning, was clearly recognised by Dr O'Kane, the current Chair, Ms Mullan and the Director of HR, Ms Toal. It was reflected in the Trust working group set up as a result of the Inquiry.[167] The group has embraced the need to adopt much of the work done at the Mersey Trust on 'just culture'. This is referred to in the Trust's written submissions to the Inquiry.[168]

210. The Medical Director in partnership with other Board members, has to play a key role in embedding the required emphasis on safety and quality. Medical leaders and managers in the services will also need to support the changes underway. This will improve medical engagement and leadership.

211. The improvements that have been referenced by the Trust, if followed through, will support medical leadership and management development; improve governance systems; ensure clarity of roles and responsibilities for medical managers; assist the journey to cultural reform; and improve strategic planning. These steps are likely to lead to an improvement in the efficacy of medical leadership and management. Achieving this will, however, require continual emphasis and investment.

212. The medical management structures led by the Medical Director have a specific role in driving the strategy and delivery of two important interconnected processes which apply to medical staff but not to other staff. Medical Job Planning and Medical Appraisal play an important part in the way doctors work and the standards they achieve. When used effectively, they are essential tools in medical management and leadership. Both should be linked to the way doctors work and the standards that are achieved and they can also play an important

167 See "People and Culture Group Terms of Reference", TRU-305063 to TRU-305067
168 SUB-00023, paragraph b

part in helping doctors to understand how their work links to the overall aims and objectives of the Trust.

213. The Inquiry found that in relation to the Acute Directorate and specifically demonstrated by the evidence in relation to Mr O'Brien, these tools were not used effectively. Leadership in this area was disconnected. Job planning was devolved to directorates. The appraisal system was run via the Medical Director's office, but there was seemingly poor understanding of how to link job planning to appraisal to improve quality and connect with clinical governance. In view of their importance, they are considered separately and specifically. The Inquiry acknowledges that the Trust is aware that improvements are needed.

Medical job planning in the Acute Directorate at the Trust

Background

214. Job plans for medical staff came into existence in 2003 as part of the introduction of a new consultant contract introduced at that time. The job plan forms part of each consultant's contract of employment.

215. The job plan takes the form of an agreement that sets out duties, responsibilities and objectives for each year set into a time-based schedule. This should ideally be reviewed annually and participation in an annual review is a contractual obligation.

216. Payment for consultants is generally based on the number of programmed activities (PAs) which are calculated in units of four hours. These can be designated as necessary for the delivery of clinical care including direct patient related administration (DCC), supporting professional activity (SPA) and additional responsibility (AR) payments.

217. It was always intended that job plans should link the work of the consultant to the activity required in each specialty, in terms of how much time the consultant

spends delivering care to patients but should also allow enough time to permit the consultants to maintain up to date skills. The job plan should agree objectives with each consultant on an annual basis. There is a mechanism within the job planning process to include paid time for additional duties over and above those required for the individual work of the consultant, such as management, leadership, education, research and clinical governance.

218. Job plans should include an articulation of the overall number of PAs to be paid, laid out in a timetable that includes explanations and a summary of all sessions worked; on call arrangements; additional duties; any special arrangements; and private work. Job plans should also include personal objectives and refer to team objectives. The job plan should also indicate what facilities need to be provided for these to be achieved.

219. Oversight of job planning is normally through the Medical Director's office accompanied by a supporting policy. The process itself is best managed by a combination of medical and operational managers working in collaboration with consultant medical staff and with the benefit of a consistency panel to ensure equity and value for money across an organisation.

220. A range of documents are available to assist with medical job planning including best practice advice as referenced below.[169] It is recognised that effective job planning is an ongoing challenge in the current complex health service environment and can be a cause of much discontent.

221. Many consultants feel that they work for many more hours than they are paid and there can be disputes relating to how this is approached.

222. Job planning should feed into the appraisal process[170] and the appraisal outcome should be available for job planning. The exact way the job planning

169 See paragraph 243
170 See paragraph 244 below

operates and the way it is linked to appraisal varies widely and it is not unusual for consultants to be disillusioned with either or both of the two processes.

The Inquiry's approach and findings in relation to job planning

223. The Inquiry sought to enquire about the processes as they were used in urology and in the Trust more generally with the aim of determining whether job planning was fully utilised as a tool for medical management and consultant engagement; how well it was linked to appraisal and what efforts had been made to link the work required from each consultant and each team to the activity requirements and overall service needs of each specialty.

224. One area of scrutiny related to the question of how well team job planning, objectives and links to overall goals of the Trust was used to set direction and aspiration, both in terms of the amount of work to be done and the standards to be achieved.

225. There might, for example, reasonably be an aspiration for the whole team to meet all the targets relating to access to cancer services along with an aspiration to comply with the best practice standards for cancer care.

226. Doctors work in teams and there is benefit in having a job planning discussion involving the whole consultant team so that the needs of the service can be considered in the round, and everyone is aware of the various issues. Even though the job plan contract relates to the individual, clinical team job plans improve consistency and understanding and hence engagement. The NHS England job planning guidance suggests starting job planning with a team discussion.[171]

227. Where doctors contribute to duties in the wider health service, there is generally an agreement that this time can be released from time committed to the Trust. In

171 See NHS England, "Consultant job planning: a best practice guide", Revised July 2017. At: consultant-job-planning-best-practice-guidance.pdf

this way the additional external roles are not generally paid for by the Trust other than via allowing time diverted from other duties. In any case this should be formally agreed as part of the job plan. This is important so that there is a realistic view of what can reasonably be done in a finite amount of time. Planning in this way helps to clarify situations where an undoable number of tasks are accumulating for an individual. The Inquiry sought to understand how this was approached at the Trust.

228. The Inquiry is aware that there is a significant administrative and managerial burden associated with effective job planning and was interested to determine whether enough support and emphasis was deployed to maximise its effectiveness. This included examining the oversight of job planning, completion rate of job plans, the use of job planning software and the cycles linking job planning to appraisal. The handling of disputes was of interest as a marker of efficiency of the process, but also a possible indicator of discontent and non-engagement.

Job planning at the Trust

229. Job planning at the Trust had been introduced under the direction of the Medical Director and Director of HR in 2004. It followed a local job planning framework which was revised in the lead up to the Inquiry.[172] The 2019 version made reference to resources and advice from the Department of Health terms and conditions of service, NHS England and Job Planning Guidance for Northern Ireland.[173] Many of the Royal Colleges have produced additional job planning guidance, often focussing on the need to define and allow time for supporting professional activities.[174]

172 See WIT-19840 to WIT-19848 and revised version at WIT-49780 to WIT-49804
173 See WIT-49782 for links to the various resources and advice
174 See: Academy of Medical Royal Colleges (2010). “Advice on Supporting Professional Activities in consultant job planning”. At: https://www.aomrc.org.uk/wp-content/uploads/2024/10/Advice_on_SPA_in_job_planning_0210.pdf

230. It appears that after the lengthy period during which the process was established, there was little oversight or scrutiny across the Trust until recent times. Dr Wright recommended the establishment of a consistency committee in 2018 and this was eventually established in 2024 by Dr Austin as a Job Planning Steering Group.[175] A previous Job Planning Steering Group had fallen into abeyance.

231. The focus on job planning was largely on getting the process in place and agreeing job plans rather than on maximising the full potential of the tool. This was affirmed by Dr Simpson (Medical Director 2011-15) who told us that just getting basic job plans in place was very slow, especially in surgery. He indicated that at the time he left the Trust in 2015, the process was still evolving. When asked about the use of objectives in job planning, he stated:

> "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."[176]

232. Clinical Directors carried most of the responsibility for completing job planning and could ask for assistance if there were problems. The time to complete effective job planning presented a problem, particularly in surgery.

233. The Trust invested in an electronic system to record job plans which many found difficult to use and which was replaced in 2022.

234. There was an admission by medical managers that job plans are not always up to date and disputes in job planning took a long time to resolve. Although there were agreed procedures to resolve disputes these were not always used, as was the case when Mr Weir tried to agree a job plan with Mr O'Brien between 2016 and 2018. He reflected that:

175 TRU-306106 to TRU-306107
176 TRA-09327, lines 24-29

> "I was trying to complete the process through engagement, which I just -- it was difficult to get the full engagement we needed to get this over the line."[177]

235. Completion rates for annual job plans remained low in many areas during the time of Dr Wright as Medical Director although work was in place to improve this. Dr O'Kane told us that by 2024 job plan completion was up to 60% and mentioned that oversight in this area was now provided via a Deputy Medical Director.[178]

236. The job plans relating to Mr O'Brien were not agreed over many years and there were various complex discussions mainly regarding time for administration. His job plan was, on one occasion, referred for mediation as per the Trust policy. He expressed his view to his job plan mediator following a meeting with him. He said:

> "As discussed with you yesterday, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I has [sic] 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!"[179]

Although Mr O'Brien was unhappy with the outcome of facilitation, he went on to say that he felt "compelled to accept the Amended Job Plan".[180]

237. These issues were never resolved as no agreement was reached as to how Mr O'Brien was to work to complete the tasks in the time he had. Moreover, the

177 TRA-02720, line 27 to TRA-02721, line 1
178 TRA-11544 to TRA-11545; TRA-11695 to TRA-11696
179 WIT-90292
180 WIT-90292

processes consumed a great deal of time and energy and clearly caused mistrust between all parties. They were in fact a symptom of disengagement between Mr O'Brien and 'the Trust'. In his witness statement Mr O'Brien referred to an email he sent to Mr Malcolm Clegg on 10 November 2011, which said:

> "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 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."[181]

238. There did not appear to be clear processes for agreeing how additional work to assist in reducing waiting lists should be managed. This is work which could attract premium rates at weekends, but it could also be completed during the normal working week. Consultants were under pressure to see more patients and do more operations, but this could mean that other duties needed to be done out of normal working hours, or on occasions normal work could not be completed. There was no explanation as to how this was justified in terms of the overall workload for a consultant. Mr O'Brien gave details of additional operating lists he completed, however he was unable to find time for his basic administrative duties.[182] Job plan discussions should describe how any work displaced by, for example, additional operating, could nonetheless be completed.

239. This situation can cause mistrust as it has the potential to be inequitable. This was discussed in oral evidence when Inquiry Counsel questioned Mr O'Brien. It was clear that no firm approach was in place with respect to job planning.[183] The Inquiry noted the fact that Mr O'Brien took on additional work but was unable to complete some of his basic duties, and yet this was not raised with him by any medical managers or by his fellow consultants in urology. In a fully functioning

181 WIT-90296 to WIT-90297
182 AOB-02029 to AOB-02030; AOB-10654; TRA-04683 to TRA-04684
183 See discussion at TRA-04685 to TRA-04688

team, the Inquiry would have expected a challenging discussion to take place, particularly where the additional work taken on by a colleague could pose an overall risk to patient safety.

240. There was no agreed process in the Acute Directorate in relation to team job planning or an agreed policy to ensure that job plans should include objectives for individual or teams so as to link to objectives for directorates or the Trust.[184] The Inquiry noted that the use of objectives was recommended in the Trust framework for job planning and in regional guidance.

241. Job plans were not clearly linked to the activity requirements for the specialty. In urology there were no discussions around team job planning.[185] Job plans appeared to be largely regarded as a payment mechanism for doctors. Mr Mackle described job plans as "a blunt instrument"[186] adding that it was not a useful tool.

242. In addition, there was no planned timetable to ensure that job plans were agreed, up to date and ready for each year's appraisal. They could not therefore be used to inform the appraisal discussion. Equally, there was no feed from appraisal into job plans.

243. The problems with job planning were generally recognised. Mr Devlin (CEO), after receiving a report from Internal Audit, realised that less than 50% of consultants had a current job plan. After Dr Wright had stepped down as Medical Director and during the time that Dr Khan was acting Medical Director, Mr Devlin asked Dr Wright to lead an improvement project in this area. Dr Wright's well-presented paper referenced best practice documents and current guidelines and set out plans for improvement. This short paper entitled, "One Direction – Ten Steps to Success", produced in consultation with medical managers, represented a reasonable improvement plan. Dr Khan presented this to the Board in 2018.[187]

184 See evidence of Mr Mackle TRA-02298 to TRA-02299
185 Mr O'Brien at TRA-04998 to TRA-05000
186 TRA-02112, line 1
187 WIT-31195 to WIT-31204

244. The paper usefully stated that the principles underpinning the job planning process should be as follows:

- "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."[188]

245. The paper also recommended that a job planning strategic oversight committee should be established. This would set strategic direction, review progress and receive reports from the job planning lead and report to SMT.[189]

246. Following these recommendations, over succeeding years, the Trust proceeded to improve matters in relation to job planning. There was an improvement in completion rates and oversight of job plans, although challenges to using job planning effectively remain.

247. The steering group established to oversee job planning (as mentioned in paragraph 230 above) sets out clear aims to address many of the issues that had been identified in previous work. It specifically mentions consistency of approach across the Trust, as well as a linkage to objectives for individuals and teams and the need to take account of Trust priorities.

188 WIT-31197
189 WIT-31202

248. Dr O'Kane spoke of some improvements in terms of job planning and appraisal, acknowledging that there had previously been what she described as a situation where the:

> "mechanism for undertaking job planning was there, but I'm not sure that it was adhered to very seriously".[190]

She recognised that:

> "one of the shortcomings in job planning as it's constructed currently is that it focuses on activity rather than quality and safety".[191]

It was her view that:

> "what we need is a job planning process, a performance management process that, you know, and performance in the widest sense in that it's not just activity it's also about quality, safety, you know, user experience, all of those things."[192]

The Inquiry agrees.

249. Overall, the evidence indicates that the value of job planning as a tool was not fully utilised during the period leading up to the Inquiry. The Trust is in the process of improving this but there is more work to do.

Medical appraisal and revalidation

Background

250. In order for doctors to be able to practice medicine, the GMC requires doctors to have revalidation of their fitness to practice every five years. The assessment of

190 TRA-11705, lines 25-26
191 TRA-11706, lines 2-4
192 TRA-11713, line 27 to TRA-11714, line 2

this depends largely on the individual doctor engaging with and completing regular medical appraisals. Revalidation is overseen by a Responsible Officer, generally the Medical Director, who recommends revalidation of a doctor on a five-yearly basis.

251. NHS England states that the:

> *"*The purpose of revalidation is to provide greater assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise."[193]

252. The GMC's current description of revalidation on their website states that:

> "Doctors must regularly demonstrate that they're keeping their skills and knowledge up to date. This process is called revalidation. Every licensed doctor must revalidate to show they are fit to practise and maintain their licence to work in the UK.
>
> Revalidation:
>
> - supports doctors to regularly reflect on their practice
> - helps doctors improve the care they give, and to identify areas for development
> - gives patients confidence that doctors are up to date
> - provides assurance that doctors are regularly checked by a senior doctor
> - helps identify improvements in organisations where doctors work, promoting the overall standard of healthcare."[194]

253. The Academy of Medical Royal Colleges who provide guidance regarding medical appraisal has further statements that back the concept of appraisal as a

193 See: NHS England Website Medical Revalidation: At: https://www.england.nhs.uk/professional-standards/medical-revalidation/about-us/what-is-revalidation/

194 See: GMC "What is revalidation?" At: https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/what-is-revalidation

supportive and developmental tool for doctors and add clarity by emphasising the link with governance and management processes:

> "Medical appraisal has evolved to become a key part of the framework of support and supervision of all doctors regulated by the General Medical Council (GMC). …
>
> Through effective appraisal, doctors demonstrate their professionalism, insight and reflective practice. Along with professional governance processes and management structures within organisations, where applicable, the outputs of appraisal assist responsible officers in making informed revalidation recommendations to the GMC.
>
> Recognising the supportive and developmental purposes of appraisal and being clear about its improvement focus will help doctors to make the most of their appraisal to plan their development and quality improvement activities. In this way, appraisal contributes to better practice and better patient care."[195]

254. Medical appraisal should help doctors to enhance their professional work, plan their own development, consider the needs of the healthcare system in which they work, put their work into context and demonstrate that they meet the guidelines of GMP as set out by the GMC.

255. The appraisal is separate from, and quite different from, job planning and it is performed by a suitably trained doctor outside the management line. The system of appraisal includes responsibilities for the appraisee and for the appraiser and it requires ongoing development, support and challenge to ensure it is used effectively.

256. A doctor's appraisal should support career development, help to encourage quality improvement and should take account of the objectives and content of the doctor's job plan.

---

195 See: Academy of Medical Royal Colleges, "Medical Appraisal Guide 2022", Introduction, page 3. At: https://www.aomrc.org.uk/wp-content/uploads/2023/07/Medical_Appraisal_Guide_2022_0622.pdf

257. Trusts should have a system of appraisers, regular cycles of appraisal and there should be senior medical oversight of the process. It should be linked to the role of the Responsible Officer who recommends revalidation to the GMC.

258. There are various documents that set out the important standards for appraisal.[196] In view of the difficult issues that may be raised during an appraisal, regular updates and ongoing training for appraisers is important.

259. In practice there are considerable problems with appraisal and the perceptions of it. For many it remains a tick box exercise which is complied with only because it is necessary for revalidation. It is the responsibility of the Trust to ensure that appraisal is used to best effect.

The Inquiry's approach to appraisal at the Trust

260. The Inquiry sought to determine whether or not the Trust had the necessary processes and structures in place to support effective appraisal. The Inquiry was interested to learn whether there were:

- Appropriate policies and documents and standardised paperwork.
- Training for appraisers.
- Ongoing development of appraisers.
- A reasonable time allocation for appraisers and appraisees.
- Sufficient oversight of the process including regular attention to audits regarding the quality of appraisal.
- Enough standardised information for the appraisee and provision to regularly update the relevant clinical governance indicators that might be useful in appraisal.

196 See: Department of Health, Social Services and Public Safety: "Guidance on Appraisal for HSC Trust Employed Career Grade Medical Staff". At: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-tc8-01-2013.pdf; and Academy of Medical Royal Colleges, "Medical Appraisal Guide 2022". At: https://www.aomrc.org.uk/wp-content/uploads/2023/07/Medical_Appraisal_Guide_2022_0622.pdf

- Reports to the Board providing a comprehensive picture of the state of appraisal including regular self-assessment against best practice standards.
- An established system for the appraisal of medical management roles.

261. The Inquiry examined these issues through the lens of the appraisals covering the work of Mr O'Brien. Clearly the Trust processes relating to Mr O'Brien's appraisals had not identified any issues of concern. This was despite the matters that were investigated in 2017 in the MHPS investigation and the matters that came to light in 2020, as well as the multiplicity of informal interventions intended to address shortcomings in practice.

262. The Inquiry is aware that appraisals are not a substitute for good clinical governance systems. They should, however, be able, with care, to detect problems and lead to learning and improvement. Appraisal is not on its own a mechanism for addressing concerns relating to doctors. While it is not designed as a mechanism for picking up previously undetected concerns, undetected problems may occasionally emerge during the appraisal. Appraisers should be equipped to recognise these and should therefore have ongoing training. They would also benefit from discussion groups to ensure that they are clear about their responsibilities when significant problems emerge and when risks to patient safety are exposed. Appraisal may and should be a forum for discussion and reflection around any important clinical issues where patient safety is at risk. Appraisal can agree plans for resolution of such issues.

263. Evidence before the Inquiry, both from documentation provided by the Trust and from witnesses, confirmed that the Trust supports the process of medical appraisal. It has an appropriate policy and standardised paperwork as well as an electronic platform for the management and recording of appraisals.

264. Although historically some assessment of the quality of appraisal was done in a rudimentary way,[197] this has not been a regular feature of Trust Board reports on

197 WIT-25872 to WIT-25934

appraisal. In 2018 there was a single sentence in the Annual Board report on appraisal referencing the fact that appraisals with information missing were returned.[198] The Regulation and Quality Improvement Authority (RQIA) provided assurance relating to appraisal and the governance arrangements feeding into appraisal in 2008 and again in 2017 and felt that processes were in place.[199] No specific recommendations were made.

265. Some supporting information was provided to consultants as a matter of course. In the case of urology, information regarding some clinical performance metrics was provided as supplied by the healthcare benchmarking company CHKS.[200] It was not however clear how this was scrutinised or whether it was used for the urology team as a whole or individually.

266. In principle the use of CHKS to provide individual level data is to be commended. Moreover, since the system extracts information from hospital information systems, it is possible that more use could be made of this resource. In using such information sources everyone needs to be aware of the risk of data errors and, unless there is total confidence in the accuracy of all the numbers, it may not be possible to use the information effectively. There is potential for more effective use of CHKS to be developed, and other clinical outcome measures could be included in the appraisal discussion. Where this is not feasible, data from national clinical audits relevant to the specialty, could be used to encourage reflection and improvement. In any case a suitable range of data reflecting quality of care could usefully be provided to the consultant for discussion in appraisal. This would need to be developed in partnership with individual specialties. The Inquiry recommends that work is undertaken by the Trust to achieve this.

198 WIT-31192
199 See WIT-43410 to WIT-43426 and WIT-58583 to WIT-58614 respectively
200 Caspe Healthcare Knowledge Systems (CHKS) was developed as a hospital benchmarking service in 1989, utilising data capture within the NHS and a range of analytics has been developed based on these

267. The Trust also provided some information on complaints, although the completeness of this was not tested. The Inquiry considers that full reflection on complaints would be beneficial and should be facilitated.

268. The Trust did not appear to mandate reflection on Serious Incidents in the urology specialty or in relation to the individual clinician as a matter of course. There was no comprehensive way of identifying all adverse incidents which may have involved the doctor.

269. There was no regular cycle of job planning and appraisal that would enable the two processes to be linked.

270. There is now a system for allocating appraisers outside the management line and a mandate to change appraisers in order to provide fresh eyes.

271. On examination of the documentation provided it is evident that in the case of Mr O'Brien, the appraisals took place in a very delayed timescale – which was a general problem at the Trust as acknowledged by Dr O'Kane who was seeking to rectify this.[201] In general appraisals did take place approximately every year, although the period addressed within the appraisal was usually over a year out of date and so the appraisal meeting did not include discussion that allowed reflection on current issues, even if these were material.

272. In the appraisal records looked at by the Inquiry there was, in general, a lack of sufficient reflection regarding safety and quality issues. This includes a lack of reflection on the IV antibiotic issue, discussed elsewhere in this Report, and the cystectomy issue. These are referred to in Mr O'Brien's 2010 appraisal only as:

> "IV fluids/Antibiotics issue has been improved by a new care-pathway defined by the Trust."[202]

201 TRA-11543
202 AOB-22200

This was a significant issue and should have resulted in discussion and full reflection at this time. There was a year-on-year absence of audit data or any reflection on departmental or other audits and a lack of discussion and reflection regarding serious incidents. The audit deficit was not corrected or highlighted other than receiving a brief mention in 2010 as an action agreed in the section Good Medical Care[203] and did not feature in the Personal Development Plans (PDPs) available to the Inquiry.

273. PDPs were often unrealistic and did not relate to the development of Mr O'Brien as a consultant. Rather they focused on Trust development requirements without indicating an achievable task for Mr O'Brien. For example, there was frequent mention of workload and demand and capacity issues but in the appraisal, it featured as an item in the Personal Development Plan (PDP) with the action: "These are Trust issues to be discussed and agreed."[204] This was in effect not an item for personal development.

274. The Inquiry was surprised that despite the matters leading up to the formal MHPS process and the process itself, there was no mandated discussion about this in the appraisal which took place in that year on 30 November 2017.[205] It was almost as if those issues and that process did not exist. This would have been a suitable time for reflection and support which would have been helpful for Mr O'Brien. There were clearly problems smouldering and yet issues were glossed over ostensibly because the period of appraisal covered was that leading up to November 2016. It is the view of the Inquiry that the medical management structure must mandate discussion and reflection in areas of serious concern, where that might be beneficial and certainly where patient safety issues are raised.

275. The MHPS investigation was discussed in appraisal the following year in 2018 which covered the year leading up to December 2017. In this appraisal

203 AOB-22196
204 AOB-22869
205 AOB-22834 to AOB-22876

Mr O'Brien presented material largely from his own viewpoint in relation to the SAI that sparked the MHPS investigation, using a reflective template in which he again stated that he found it impossible to complete triage.[206] The fact that the delayed cancer diagnosis resulting from missed triage had been investigated as a major problem and was a clear risk to patient safety,[207] did not feature in any way that demonstrated insight into the full extent of safety concerns on Mr O'Brien's part.

276. In that year's PDP, the need to complete triage and dictation were listed as personal development goals from the previous year[208] even though these are basic tasks which should be completed as part of a job plan. However, there is no evidence that Mr O'Brien was encouraged to think more reflectively on these matters, or that he was challenged in any way. This appraisal could have been used in a more developmental way given the circumstances. When Dr Khan referred to the need for an enhanced appraisal,[209] he almost certainly envisaged an appraisal that would result in a more developmental PDP.

277. The appraisal did not fully cover the whole scope of practice and in particular no information about private practice was recorded. Mr O'Brien's practice of allowing private patients to be admitted as health service patients for investigation and surgery without formal transfer into the health service system could have been picked up in the appraisal sessions with some basic questioning in this area. In any case he should have been asked to provide information about the scope of his private practice and his approach to it. He should have provided some evidence relating to the quality of his private practice.

278. Overall, in relation to Mr O'Brien, the appraisals conducted were not sufficiently robust to allow a full developmental conversation. Examination of the paperwork raises issues relating to the adequacy of the appraisal process more generally.

206 AOB-22947 to AOB-22950
207 AOB-22956 to AOB-22957
208 AOB-22961 to AOB-22963
209 TRA-04050 to TRA-04051

It is surprising that Dr Khan as acting Medical Director did not himself examine the appraisals relating to Mr O'Brien given the seriousness of the issues raised.

279. Board reports on medical appraisal did not regularly include assessment of the process against best practice standards and there was insufficient emphasis generally on the quality of appraisal. The tolerance of delayed appraisals and lack of connectivity with job planning are further significant areas for concern.

280. The Trust has recognised that improvements are required in this area and has committed to improving the application of appraisal. It also now recognises that an appraisal process is needed for medical management roles.

281. Dr O'Kane described current progress in this area. Appraisal is now led by a Deputy Medical Director reporting to the current Medical Director and supported by an operational manager. The current Medical Director, Dr Austin, provided a report to the Trust Board outlining a number of improvements in the application of medical appraisal.[210] This report announced the creation of an Appraisal and Revalidation Board to oversee appraisal and revalidation and provide assurance to the Trust Board.

282. As part of the understanding of the need to improve assurance in this area, Dr O'Kane referred in her evidence to a new process. It is designed to ensure that appraisal relates to the immediately preceding period rather than being delayed, to regular and ongoing training and discussion meetings for appraisers and for themes from appraisal to be selected for discussion with the senior medical leaders.[211] She acknowledges that previously appraisal was, in her view, somewhat superficial even though the basic structures for appraisal were in place.[212]

210 TRU-306108 to TRU-306116
211 TRA-11714 to TRA-11717
212 TRA-11706

283. In her witness statement, Dr O'Kane also outlined a range of improvements the Trust has underway in the area of medical professional governance.[213]

284. By establishing a HOS post to support the Deputy Director overseeing revalidation, improving the involvement of Divisional Medical Directors in appraisal and revalidation, improving the oversight of MHPS processes, establishing the Doctors and Dentists Oversight Group, as well as the Revalidation and Appraisal Board, the Trust has demonstrated a clear recognition of the need for improvements in this important area.

285. The approach is credible but full implementation will require ongoing support in the form of sharing best practice regionally, good data systems to provide supporting information for doctors and development programmes for medical managers and leaders, as well as medical staff more generally. This is a key part of the development of the medical workforce and should be in receipt of targeted funding.

Conclusions and recommendations

286. The Inquiry supports the improvements in medical leadership and management at the Trust as described in evidence and in its submission but considers that further developments will be required, including in the areas of medical job planning and appraisal.

287. The Inquiry considers that strong medical leadership is an essential part of ensuring accountability, governance and patient safety within healthcare organisations and that the Trust should be supported in a specific programme of work to develop the medical workforce so that it can take on this challenge.

288. The imperative for strong medical leadership is increased by the combination of pressures on the Trust, including this Inquiry. Leading the programme of

213 WIT-45014

transformation described by Board members during the Inquiry, will require full engagement of doctors as well as all other staff.

289. The Medical Director, assisted by other senior doctors, should develop and lead a specific funded programme of work that sets out to ensure that medical management and leadership roles and responsibilities are clear, that there is sufficient time to do justice to the jobs and that there is ongoing targeted development for medical staff linked to a wider organisational development plan.

290. The Trust would benefit from some targeted staffing support led through the Medical Director's office to develop these processes relating to doctors. It should be set out as a project plan for improvement. Such a plan would benefit from working with a 'critical friend' or partner to adopt any best practice that is relevant in this area.

291. The Inquiry considers that this work would benefit from a Northern Ireland wide approach, one which would be capable of bringing learning and recommendations from the Independent Neurology Inquiry, as well as the learning from Inquiries more generally. Accordingly, the Inquiry recommends that the Department helps to develop a regional process. This process would need to have regard to the following comments:

- There is a need to improve the engagement of doctors with the vision and objectives of the organisation, so they feel more connected to it and move away from considering 'the Trust' in what could be described as a 'them and us' way. Although senior medical managers have grasped this there is a need for all consultants to grasp it in a more comprehensive way.
- Job planning cycles need to be more responsive and completed in a meaningful way to include objectives, with team discussion to ensure perspective and links to capacity plans. The discussions should include operational as well as medical managers. As far as possible, information to cover the full scope of work should be included as part of the job plan

discussion which includes the need for development of a range of quality metrics.

- Appraisal would benefit from revitalising and benchmarking against current best practice. This should include recommendations, including statements relating to assurance for patient safety as recommended by the Academy of Royal Colleges and should include the relevant recommendations from the Independent Neurology Inquiry.
- As part of the medical leadership development programmes, further development work is needed for the medical staff body to ensure that consultants understand the connections between appraisal and job planning, the value of them if used to best effect and develop skills and insights that will help prepare them for leadership roles in the future. The current guidance from the GMC relating to management and leadership responsibilities for doctors should be emphasised as part of this. All consultants would benefit from presentations from the GMC on this topic which could usefully also cover the 2024 revision of GMP.
- The Trust should have an ongoing programme of work to assure the quality of appraisal and should also benchmark against the GMC guidance relating to governance arrangements to support appraisal. The availability of clinical outcome data would assist in this area.
- The Inquiry has heard evidence that the Board are aware of the importance of a programme of cultural change and have worked with Mersey Trust and other advisors in order to understand and embrace the concept of a ‘just culture’. The Inquiry has also heard that there are plans for a full organisational development strategy and the Inquiry would endorse these initiatives. This will require a comprehensive change programme in which medical leadership should play a key role and this would also benefit from Northern Ireland wide support. Accordingly the Department must be involved in developing this regionally.
- It is also clear that given the operational pressures currently at play it will be particularly important to establish a clear vision and agreed values for the Trust. We understand this work in is progress and the need for it has been endorsed by the Board.

- Additionally, it is important that all doctors, even if they are not in formal management or leadership roles, understand their duty to raise patient safety issues, and appreciate how those concerns should be escalated and where action will be taken and by whom. This requires careful attention to the way organisational structures, particularly around clinical governance and operational governance, are working in practice, and not just to the structures themselves.

292. The Inquiry has heard about a range of improvements that have been put in place or are planned at the Trust. The improvements described should result in cultural transformation, a clearer vision for services including an emphasis on safety and quality for patients, improved clinical governance and improved staff engagement generally. These changes should encourage high quality medical leadership which will in turn be required to lead the transformation of services to which the Trust aspires.

293. The Inquiry considers that in the face of the very real operational and financial pressures which will continue to exist, doctors have a key role to play in ensuring an appropriate balance between the various competing priorities in a way that assures safe, effective patient care.

Contents – Conclusions and Recommendations

Conclusions and Recommendations

1. This Inquiry came about as a result of concerns about the practice of one consultant in one service in the second biggest Trust in Northern Ireland. Those concerns were the gateway to consideration of the issues of governance within that service, within the Trust and more widely, within the region.

2. We found evidence that despite pressures of waiting lists and lack of resources, the workforce was committed to providing the best care that they could. Staff, clinical and operational alike, were generally reflective and displayed a willingness to learn and improve. They sought to give a balanced account of the issues that came to light. We were encouraged by the improvement efforts undertaken by the Trust and the Department during the work of the Inquiry and concluded that both have considerable insight and awareness regarding the findings as they emerged during evidence.

3. We have, therefore, asked ourselves how we can make recommendations that will be helpful to the Department and the Trust. Recommendations that will make a difference for those working in our healthcare systems, but primarily and more importantly, for the patients in their care.

4. Rather than prescribing detailed operational solutions, the Inquiry has sought to identify the areas where focused effort is required and where progress would have the greatest impact. The recommendations are therefore intended to direct attention and resources to those areas that we have identified as requiring more work, while allowing the Department and Trusts to determine the most effective means of implementation. Where necessary, such work will require support from external expertise. This will undoubtedly involve the identification of people, including medical leaders and patient safety experts who can advise and offer critical challenge. There are, nonetheless, some matters where we can direct change that ought to be readily achieved.

5. The Inquiry has reached conclusions on the evidence and made suggestions and recommendations in the preceding chapters. Recommendations in this Report flow from the various criticisms levelled throughout those chapters and from the comments covering areas for improvement. This section cannot be read in isolation but should be read in conjunction with the other chapters of the Report. Throughout we have been conscious of hindsight and in full understanding of the significant challenges that were faced and are being faced in our health service.

6. The Inquiry has considered the findings and recommendations of numerous previous inquiries into healthcare failings that have burgeoned over recent years.[1] Although we recognise that Health is a devolved matter in Northern Ireland, a number of the Inquiries relating to events in other parts of the UK need to be borne in mind when dealing with patient safety matters. Regrettably, our findings echo many of those found by other inquiries and we have drawn on learning from other Inquiries. The problems experienced by the patients and staff at the Trust reflected problems identified in previous investigations into failings in healthcare. The fact that the same issues arise repeatedly in healthcare is clearly a cause for concern and points to longstanding systemic issues that have yet to be fully addressed.

7. The Inquiry notes that as recently as April 2026 there was a thematic review of 15 cases from the urology department in East Kent Hospitals University Foundation Trust. This was triggered by a series of incident reports and findings that included findings similar to those we found in this Inquiry including:

- Problems tracking patients for many cancer pathways, leading to a failure to organise follow-up appointments;
- Critical alert emails, which would have triggered action, not being sent after scans and pathology reports; and

[1] The Thirlwall Inquiry published a review of Recommendations from Previous Inquiries into Healthcare issues in England and Wales updated to April 2025. At: https://thirlwall.public-inquiry.uk/2024/05/17/review-of-previous-recommendations-published/?d102_cookies_enabled=essential

- The absence of a "safety net" system to ensure referrals were not missed.[2]

Essentially, in that hospital trust there were delays in diagnosis, treatment and delayed referrals to oncology. The department was having difficulty coping with the volume of referrals.

8. Successive UK and Northern Ireland governments and organisations have accepted recommendations from previous inquiries. Despite intentions to implement those recommendations and despite significant work to improve systems, processes and culture, failings in healthcare continue to occur and the implementation of recommendations is incomplete. The Inquiry is conscious that the reasons for this are complex, but at the core of these shortcomings is that, despite good intentions, health care providers have failed to consistently uphold a fundamental principle expressed by Sir Robert Francis in his Report and reiterated by the government's response to Francis. This was to ensure that patients were:

> "the first and foremost consideration of the system and everyone who works in it."[3]

This Inquiry considers that there must be a return to that basic principle and that any recommendations we make or actions taken must be informed by it.

9. The Inquiry recognises that there is no shortage of guidance, regulation or policy relating to the delivery of safe, high-quality care. The challenge lies not in identifying what should be done, but in ensuring that agreed actions are implemented, monitored and sustained. Where guidance in all its forms is not followed or when standards of care are inadequate, then governance systems

---

2 See: "Exclusive: Deaths linked to 'overwhelmed' department" by Moore, A. (2026). This is a Health Service Journal article based on information obtained directly from the Trust. The article can be accessed by subscribers to the journal.

3 Francis, R. (2013) "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry". At: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

should be capable of highlighting problems and recommending relevant actions as required, ideally before there are major issues or harm events.

10. When things do go wrong there are ways of reporting and investigating, plans for improvement are made and action plans agreed. There is, however, always an overarching need to ensure that action plans are not sterile documents but rather are continually looked at and adapted as required. They have to be instruments for change supported by leadership commitment and effective oversight.

11. After investigations and inquiries there is a tendency to recommend more scrutiny, more governance, more oversight and more regulation. Despite this the problems continue. This Inquiry has tried, for this reason, to not be entirely directive or prescriptive with regard to its recommendations.

12. The Inquiry commends the development of the learning from Inquiries workstream in Northern Ireland[4] and the discrete pieces of work reported in the Ministerial Statement in February 2026,[5] including: the Serious Adverse Incident Framework;[6] the Being Open Framework;[7] the establishment of Patient Safety and Quality Committees;[8] a draft updated Board Member Handbook as well as the formal adoption of the Model Complaints Handling Procedure (MCHP)[9] in January 2026.

13. The Inquiry considers that these strands of work are all important improvements that align with the evidence and recommendations from this Inquiry. They all

4 See Hansard Official Report, "Minutes of Evidence: Inquiries Implementation Programme Management Board: Department of Health", 18 September 2025. At: https://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=36986

5 INQ-21286 to INQ-21291

6 Department of Health, "Serious Adverse Incident Redesign Programme: Framework for Learning and Improvement from Patient Safety Incidents", Consultation Document (March 2025). At: https://www.health-ni.gov.uk/sites/default/files/2025-06/Framework%20for%20Learning%20and%20Improvement%20from%20Patient%20Safety%20Incidents%20-%20Consultation%20document.pdf

7 Department of Health, "Being Open Framework for Health and Social Care in Northern Ireland". At: https://www.health-ni.gov.uk/publications/being-open-framework-health-and-social-care-northern-ireland

8 See footnote #5

9 Department of Health: HSC Complaints – Standards and Guidelines. At: https://www.health-ni.gov.uk/publications/hsc-complaints-standards-and-guidelines

support an increased emphasis on safety and quality, a more open learning culture, an improvement in the involvement of service users and most importantly, they signal an approach that recognises the importance of supporting cultural change rather than focusing on increasing regulation. This is best illustrated by the RQIA's Being Human Framework which was co-produced with numerous stakeholders in order to assist Trusts to develop programmes of cultural change.[10]

14. From our consideration of other Inquiries, the recent developments in Northern Ireland and the evidence we have received in this Inquiry, we have identified three overarching themes and areas for action which would support current programmes of work. These require sustained attention at system level if meaningful and lasting improvement is to be achieved. They are:

- The formal **declaration of patient safety** as the dominant and primary purpose of health provision.
- A comprehensive **leadership development programme**.
- Investment in **data and information**.

15. We recommend that patient safety should be formally adopted as a core purpose for health care. This should be supported by a patient safety strategy and implementation plan which would give meaning to this core aim and align the current important programmes of work that are already in place. Formally declaring patient safety as the dominant and primary purpose of health care would send a clear signal to patients, families and health and social care staff. It would assist in producing a necessary change in emphasis in order to embed an open learning culture. Patients, families and staff should understand that adhering to ministerial targets is important and it is important to use resources effectively, but safe, high-quality care must remain the overarching aim. This means that everyone needs to understand that managing targets, money and

10 Health and Social Care/RQIA, "Being Human: A Framework for Safety Culture within Health and Social Care in Northern Ireland". At: https://www.rqia.org.uk/wp-content/uploads/2026/01/Being-Human-Framework-for-Safety-Culture-A4-DIGITAL-Doc-160126-compressed.pdf

safety should not be considered mutually exclusive aims. In making this recommendation the Inquiry draws not only on the observations from evidence presented to us, but also on the work of organisations and groups focused on patient safety.

16. One example is the charity, Patient Safety Learning.[11] In a number of its publications including: "The Patient-Safe Future: A Blueprint for Action"[12] the charity comments on the difficulty posed by regarding patient safety as a strategic priority to be balanced against other priorities. It suggests that real progress requires that patient safety is formally adopted as a core purpose for healthcare. The Inquiry agrees with this viewpoint. We consider that there is a need for a Northern Ireland system wide patient safety strategy as recommended by the Northern Ireland Public Services Ombudsman (NIPSO).[13] Such a strategy could encompass many of the themes for action/recommendations from this Inquiry as well as the significant learning from safety incidents. It should also include an emphasis on culture and measurement. Perhaps most importantly the strategy should emphasise that patient safety has to be system-wide:

> "A Patient Safety Strategy setting out how our health system is prioritising safety and involving patients in the process would provide reassurance and help build public trust in a health system that is committed to being patient centred."[14]

The Inquiry notes the very significant work in this area in Northern Ireland as referred to above and considers that our recommendation would only serve to strengthen and extend current work in this area.

11 www.patientsafetylearning.org
12 INQ-31069 to INQ-31166
13 Northern Ireland Public Services Ombudsman Conference Report: "Patient Safety – Public Trust A decade of inquiries – what is the learning?", at: INQ-21004 to INQ-21023
14 See: NIPSO "A Patient Safety Strategy for Northern Ireland. At: https://www.nipso.org.uk/search?search_api_fulltext=margaret+kelly

17. The Inquiry's recommendation that there is a significant emphasis on leadership development has drawn on the work of Sir Gordon Messenger[15] in relation to the importance of leadership development that is focused on a clear sense of purpose. The Inquiry is cognisant of the very real leadership challenge presented in the current health and social care system and realises that improvement requires money and time to develop exceptional leaders. Embedding a learning culture as advocated in the 'Being Human Framework' will require strong leadership at every level in health and social care. Each part of the system will need to consider what is required and how to implement it. Whatever programmes are devised, however, formally establishing patient safety as a key system aim will assist in driving the cultural change that is of prime importance.

18. In recommending a significant focus on data and information, the Inquiry has considered our own findings, as well as repeated recommendations from other inquiries in relation to the need to improve the availability of meaningful data on quality of care for both service users and staff.

19. None of the bases for our recommendations are new, nor is there a lack of awareness of their importance, however the Inquiry considers them to be foundational but insufficiently embedded in practice. They underpin all of the specific areas for action identified in this Report and should be addressed in a coordinated and coherent manner across Northern Ireland. Doing this will ensure the safe care of patients, promote the well-being of staff and improve our health care system.

20. We acknowledge and commend the improvements that have been taking place both in the Trust and regionally. We recognise, particularly, both the Trust's recognition of the importance of cultural change and the important work done by the Department referenced above. We specifically note the strong emerging emphasis at Department level on the importance of cultural change. We consider

15 See: Sir Gordon Messenger Review (state of leadership and management in the health and social care sector). At: INQ-20577 to INQ-20605

that all of these developments need to be further championed by an overarching patient safety strategy to promote a core system aim of patient safety.

21. The Inquiry was mindful of the significant challenges in health and social care faced at the Trust, in Northern Ireland and more widely in the UK. The Inquiry considered that it was important to understand these but did not regard them as a rationale or excuse for poor governance and leadership. The Inquiry considered that the challenges faced were, and are, so significant that they are already causing exhaustion and disengagement of the workforce in health and social care.

22. The mismatch between demand for healthcare and the capacity to deliver it is substantial. There is insufficient investment in both human and physical infrastructure. There are severe financial pressures. Regulatory arrangements are complex and there is constant change and reorganisation. Very significantly, there has been a failure to consistently engage with patients and the public in a way that is meaningful. As a result, patient expectations are not met.

23. In the course of our work we have identified seven main areas in which, although some work has been undertaken, more is required in order to improve patient safety and the quality of care. Although the Inquiry's work focused on one department and one health and social care provider, the Inquiry considers that the lessons learned are applicable more widely and that solutions will require a system wide approach if they are to have the greatest impact. Some of these areas for action overlap and in addressing each, any action plans devised must bear in mind the three primary recommendations which underpin them. In each area for action patient safety focus in its widest sense, leadership development, and adequate information systems will bring about effective change.

1. Patient focus including complaints

Background:

24. Many inquiries have highlighted problems relating to the failure to listen to patients and their families, especially when things go wrong. This is often evident in complaints processes and investigations into failings of healthcare. Effective involvement of patients and families helps to provide safe care for the patients themselves and is an important part of improving systems of care.

What we found

- Patient involvement was generally poor. There was inadequate communication with patients and their families about care plans and treatment options. The Inquiry noted that there is no mandate for clinicians to write to patients directly, as recommended by the Academy of Royal Colleges. Unless this is in place it may be difficult to know exactly what patients are told or understand how their views have influenced treatment decisions.
- Patients had difficulty accessing information. When they needed to contact the Trust to enquire about appointments, scans, results or procedures, many interactions and informal concerns were not formally logged and there did not appear to be a clear process for resolving concerns or queries. When formal complaints were raised, there was insufficient discussion with the patient and responses could be delayed or lacked senior, independent oversight. There was insufficient focus on meaningful learning and too much focus on processes rather than on personal contact with complainants to ascertain what mattered most to them.
- Patients were not always aware that things had gone wrong and there was no mandatory duty of candour.
- There was a lack of regular patient feedback for every service as part of normal governance processes.
- There was insufficient patient involvement in Serious Adverse Incident (SAI) investigations, even though the benefit of involving patients is well recognised.

- There was no evidence of any structured planned involvement of patients in service redesign and learning.

Comment

25. The Trust was aware that the involvement of patients and families needed to be improved after SAIs. It did involve patients and families in the SAIs that led to this Inquiry. More recently, the Trust has made further improvements and has implemented a new policy to strengthen the approach to be taken, as discussed in the SAI section of the Governance chapter. The issue is addressed by the draft Framework for Management of SAIs in Northern Ireland. The Department will need to provide ongoing discussion and support during implementation of that framework in Trusts. The Inquiry fails to see how this framework can be effective without implementing a mandated Duty of Candour to strengthen the "Being Open Framework" recently launched. Importantly, the framework does highlight culture and leadership in organisations and the importance of sharing information in a way that focuses on learning. The Inquiry notes Minister Nesbitt's statement to the Assembly dated 18 September 2025 regarding a Duty of Candour Bill[16] and would urge progress on this.

26. The Trust has also made some improvements to its complaints process following the Champion review[17] and recognised the need for improved service user involvement. The Inquiry also notes the new guidance issued by the Department regarding the management of complaints[18] which was introduced in January 2026 in Northern Ireland, formally adopting the MCHP developed by the Northern Ireland Public Services Ombudsman. It is referred to in the Minister's written statement of 19 February 2026.[19] We consider that this provides a good basis for improvements in this area in all of Northern Ireland's Trusts.

---

16 See Written Ministerial Statement 18 September 2025. At: https://www.niassembly.gov.uk/siteassets/bv180_dh_180925.pdf
17 WIT-00507 to WIT-00567
18 See Footnote #9 above
19 See Footnote #5 above

27. Overall, however, the voice of the patient is still not strong enough. One patient put it succinctly when telling the Inquiry:

> "We are people, we are real families and we need a voice."[20]

Further work is required to give patients an effective voice.

Recommendations

28. The Inquiry recommends that the Trust and Department work together to ensure there is:

- A specific programme of work to strengthen patient involvement, improve communication, and ensure patients and families are treated as partners in care.
- Direct communication with patients as standard practice.
- More effective handling of concerns and complaints, with an emphasis on early resolution, learning and advocacy support.
- Routine collection and use of patient experience data and transparent public reporting of quality and outcomes in accessible formats.

29. Such a programme of work should involve patients and the Patient and Client Council (PCC) as well as senior leaders and Trust Board members. It should include both an agreed strategy and prioritised implementation. Leadership for the plan should be clear. It should be overseen both at Trust Board and at regional level by the Department. The programme should include work on how to involve and support vulnerable groups and is likely to benefit from a learning partnership type of approach.
The programme should also include:

- A mandate to write directly to patients so that they are fully involved as partners in their own care.

[20] Paragraphs 339 and 381 of the Patient Chapter

- Directions regarding the framing and style of all communications with patients and families.
- Further work on the most effective way of involving patients and families in the framework for managing incidents and in the complaints process, taking account of the most recent policies in this area. This should include an agreement on whether to legislate for formal patient advocacy as recommended by the PCC, or whether an alternative effective approach is sufficient.
- A plan for how best to ensure a smoother system for responding to patients about day-to-day queries, concerns and issues with services. The aim should be both to provide relevant and necessary information to patients and to enable resolution of matters at an early stage, before formal complaints are raised. This should also include work on how best to communicate with patients on waiting lists, so they are not left unaware of their place on the waiting list and have clarity about what to do should their condition deteriorate. There should be a system to record harm to patients as a result of very long waits, so that this can be automatically highlighted to clinicians, managers, leaders and patients.
- An agreed plan to outline how to involve patients in improvement work and learning from error as well as in strategic planning of services.
- Guidance on the most useful way of capturing patient experience information.
- Guidance on the best way to provide information on quality, safety and patient outcomes in the public domain in a way that is accessible to patients and families.

2. Organisational development and cultural reform

Background

30. Recommendations from failures in healthcare nearly always speak of a need to improve culture, which may or not be specifically defined. One important aspect of improving culture is the need for all staff to focus on safety and quality and for

views to be aligned. It seems that the Trust's staff recognise this. Dr Maria O'Kane described staff views to the Trust Board:

> "The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust."[21]

31. There are many other important enablers that influence the development of healthy cultures including reliable systems of care, adequate resourcing and staffing and clear systems for listening to staff and patients.

32. As stated, there has been much emphasis on the need to improve culture in healthcare while recognising that culture is difficult to change. The development of the concept of 'just culture' is one way of helping organisations to develop a clear aim focused on outcomes understood by all.

33. The Inquiry notes and commends the recent work in this area referenced above (Being Human Framework) which highlights the importance of culture in achieving meaningful changes.

What we found

34. The Inquiry considered that there were several cultural influences that undermined openness, learning and patient safety.

    a. Negative influences included:
        - professional divides and silos;

[21] TRU-303681 to TRU-303682

- lack of clear goals relating to quality and safety;
- lack of good quality information;
- insufficient leadership capacity;
- normalisation of failure;
- pressure of work; and
- excessive hierarchy and a tolerance of transgressive behaviour.

b. Leadership attention was concentrated on meeting mandatory targets and goals, while ostensibly still supporting the need to provide high quality care. Many staff told us of the focus on ministerial targets and finance at the expense of other efforts.
c. The escalation of significant issues to senior members of the Trust was inadequate. The Inquiry formed an impression of selective reporting.
d. Safety risks relating to patients on waiting lists were not formally and openly discussed. There was no structured programme of work to assess and ameliorate waiting for those with the highest risk. Harm appeared to be tolerated and normalised.
e. There was tolerance of idiosyncratic clinical practice without realisation that it presented risks to patient safety.

Comment

35. The Trust Board recognised the need for change. The Trust has been engaged in improving governance since the launch of the Inquiry and programmes to achieve better governance are ongoing. These remain critically important and are to be encouraged. Both the Chair of the Trust Board and the then Chief Executive Officer (CEO) recognised the need for cultural reform. They acknowledged the Board's role in driving that reform. This role includes fostering psychological safety to ensure that staff feel able to speak up when there are risks to safe care and are confident that this will result in learning, action and improvement. Although work has begun, this has not been formally set out in a comprehensive programme of organisational development. Such a programme

has to be fully funded and aligned to agreed values with aims, objectives and strategic plans.

Recommendations

36. The Inquiry considers that the work underway at the Trust should continue and be supported by the Department. We note the recent launch of the Being Human Framework to support Trusts in developing an open learning culture and note references to a just and open culture, advocated by the Health Minister in his introduction to the new Serious Incident Framework.[22] Embedding cultural change is clearly a long-term project which should be overseen by a regional working group. The Trust's approach to the Inquiry provides significant learning for the wider system and could be used to develop and accelerate progress more widely. The Trust benefitted from the use of critical friends in developing their thinking and accelerating action. The Inquiry commends this approach and considers that it could be used in further improvement work at the Trust and at regional level.

37. The Inquiry recommends that:

- The Department should continue to emphasise the importance of cultural change as shown in current work and formally recognise that this contributes to a system wide focus on patient safety as a core system aim. Devising a Northern Ireland patient safety strategy would consolidate and clarify the various strands of work in progress.
- The Trust should continue and strengthen its organisational development work. This should be aligned to a clearly articulated commitment to a just, open and learning culture.
- To ensure that each staff member understands their role in patient safety and the meaning of an open and just culture, the Trust should develop a fully funded development programme for all staff, including clinical staff in training. The programme should address what specific leadership development is

[22] See Footnote #6 above

required for staff and specifically, how best to ensure alignment between professional groups. Medical staff benefit from bespoke development, as do nursing staff and operational staff but there is also benefit in training groups of staff together, especially in the context of advancing an understanding of shared aims, such as patient safety. This programme should ensure that all staff understand how this aligns with Trust processes, aims and objectives, and more widely with these same objectives at a regional level.

- Specific consideration should be given to what ongoing data would best support the oversight of work to prioritise safety, so that this can be openly measured and tracked. Regard should be had to suitable resources such as "A framework for safety measuring and monitoring".[23]
- This programme should be supported and monitored by the Department with a view to using it as a model across Northern Ireland.

3. Board and senior leadership development

Background

38. Trust Boards have a key role in driving the culture of organisations as expressed by the statement from the current Chair of the Trust:

> "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."[24]

39. The leadership challenge of balancing the various competing priorities in healthcare is considerable and further problems may arise due to instability of leadership in organisations and insufficient ongoing training and leadership development.

---

23 See Chapter 5 of: "The measurement and monitoring of safety. Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring", published by the Health Foundation. Available at: https://www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf

24 WIT-100557

40. Like Sir Gordon Messenger, we observed that:

> "The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user."[25]

In simple terms there is a real risk that leaders and managers try to satisfy regulators and commissioners rather than the patients they serve.

41. A number of other findings from the Messenger Report echo with the views of the Inquiry. We noted problems relating to organisational and professional hierarchies and agree that medical leadership is particularly important, as is clarifying a unifying sense of purpose. We also agree that the solution to these issues requires significant investment in leadership for all staff entering the health service. We too, like Sir Gordon Messenger, acknowledge and respect:

> "the everyday commitment, determination and goodwill of leaders and staff at every level to improve outcomes and experience for patients and service users".[26]

42. Boards and senior leaders often benefit from development programmes that are designed to broaden horizons, improve knowledge, especially in the field of patient safety, increase their curiosity and develop better understanding of the changing health and social care landscape.

43. The Board's duty to ensure that there are safe systems for delivering high quality care depends on careful attention to systems and processes of governance. It requires alignment of strategies, aims, objectives and delivery. Boards cannot function effectively unless they also maintain connections with frontline patients and staff. Boards cannot discharge this difficult set of duties without constant self-

25 INQ-20579
26 INQ-20578

reflection and improvement. Many inquiries have found failings in aspects of Board effectiveness.

What we found

- The accountability of the Board for setting strategic direction and leading the organisation was not sufficiently clearly developed.
- Board training was not sufficient to ensure effective self-reflection or a full understanding of the breadth of issues related to promoting a safety culture.
- Leadership and management capability did not seem to be sufficiently well developed. It was not connected from the Board, through the Senior Management Teams (SMT), to each directorate and service in a clear way.
- Medical leadership was insufficiently developed and supported. There was inadequate time allowed for performing these important roles and a lack of ongoing training.
- The Board did not clearly recognise its own duties in ensuring that there were systems in place to assure it that standards of care were working as intended.
- The Board in general appeared to be more concerned with reporting mandatory compliance measures rather than setting direction and learning from best practice.
- When matters were formally raised to the Board, appropriate discussions were evident, however there were many things that the Board was not appraised of.
- There appeared to be a culture of acceptance of reassurance and a degree of helplessness with respect to some very significant systemic problems.

Comment

44. Since the Inquiry began, the Board has made constructive changes and governance improvements. The Board's approach to learning from what unfolded during the Inquiry is to be commended. The use of critical friends to assist in the development of thinking and hence a commitment to act was an efficient and effective way to start the process of self-reflection and improvement.

45. Board members described the positive impact of changes and voiced commitment to ongoing work to improve openness, learning and a focus on patient safety. There have also been significant improvements in many aspects of governance at Trust level, Directorate level and at the service level, resulting in clarification of responsibilities. Board members and senior leaders will inevitably continue to require support and training, including from the Department, in order to continue to improve and transform services in the way to which they aspire.

Recommendations

46. The Inquiry recommends:

- The Department implements and funds a bespoke, regional leadership development programme for Board members and senior leaders, co-designed with external expertise including specific training in patient safety. This will complement the recently updated Board Handbook which provides excellent guidance and, if used as intended, should provide the basis for an effective Board. Such a programme should be devised with input from Trusts and professional group leaders and be informed by the work of this and other inquiries.

  The programme should:

  - ensure that all staff have sufficient understanding of their role in patient safety and incident reporting. Any plan must ensure that they understand the overall aims of the health and social care system;
  - ensure that each professional group is assisted as needed to develop their professional duties as individuals and also to understand how they must work together in multiprofessional teams to deliver shared aims and objectives. In practice this will require each profession to have training directly relevant to it and then for combined training with other professionals in the team;

- determine how those with leadership and management responsibility are developed to understand, develop and deliver their services as a management team at each level; and
- determine how the executive team and the Board is developed to fulfill their duties. This will require a consolidation and refresh of the leadership development programmes currently available.

- The Department should facilitate discussion and debate regarding the work done in the Trust as a result of its engagement with the External Reference Group (ERG) with a view to continuing this approach. We recommend that the discussion includes consideration of a partnership arrangement with an organisation who has successfully brought about a cultural change. This would provide the Trust with the benefit of a critical friend who could add value in a pragmatic way.
- The Trust should formulate an agreed approach to ongoing Board development for the future, including lessons from the Inquiry and the events that preceded it. This should include specific training in the field of patient safety, including best practice in this area for all Board members and senior managers.
- The Department should review current methodology for Board self-assessment and guidance on Board composition. Consideration ought to be given to greater clinical input and more service user feedback and representation on the Board.
- Each Trust should appoint a Senior Independent Director (SID) as is recommended by NHS England.[27] A SID is a Non-Executive Director with enhanced responsibilities. The SID can function as a sounding board for Board members or others who feel they cannot raise issues through normal mechanisms. The SID provides support to the Board Chair, as required, but is a point of contact regarding any issues with the Board Chair.

27 NHS England, "Code of governance for NHS provider Trusts", (October 2022), at: https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

- The Trust should devise its own programme of work to agree on how best to implement ongoing leadership development for all Board members and Trust senior managers. This should include clarification about how to link into specific leadership development for medical managers, or other professional groups. In addition, the connections with wider organisational development programmes and regional development programmes should be clearly described in a way that ensures that there is a clear alignment of purpose. The comments and recommendations of the Messenger Report are relevant to such a programme of work.

4. Governance

Background

47. Effective governance systems and processes are critical components of safe effective health and social care. The more complex and pressurised systems are, the more important it is to be able to automatically read and act on signals that might highlight problems. Equally, effective assurance concerning the reliability of systems and processes, using agreed data flows, can simplify oversight. All efforts can be concentrated where they are really needed, and staff and patients can understand as much as possible about the quality of care provided.

48. Reflecting on the evidence presented in the Inquiry, the Trust acknowledged the need for a data strategy. Other Inquiries have made various recommendations indicating the need for data gathering that reflects quality of care.[28] In each case recommendations have been accepted but not fully implemented. This does not relate to a lack of willingness but rather to deficits in data and information systems.

[28] These include the Patterson Inquiry, the IHRD Inquiry, the INI and the East Kent Inquiry

What we found

- The Trust had many of the structures required for good governance and had invested resources in assessing these by the time that the Inquiry commenced. A review of governance was conducted by June Champion from the Leadership Academy.[29]
- Several of those who gave evidence to the Inquiry were critical of the governance systems in place at the Trust. The Champion Report confirmed many of the views expressed.
- The Inquiry received evidence of a very wide range of improvements and was assured that the improvements were being updated and refined as required. The Trust continues to track the actions recommended by the Champion Report. The Inquiry considers that this would benefit from a fresh look, including a review of the impact of these changes, and an assessment of how the Trust will know that improvements are having the intended consequence.
- The findings of this Inquiry echo many of the themes in the Champion Report, but there are differences and the Trust should look at any additional matters we have uncovered. One example highlighted in the evidence before the Inquiry was the issue of the oversight of information governance, but there are likely to be others.
- Governance systems are always in constant need of review and formal reviews need to be pragmatic. Given the complexity of healthcare and the many demands for assurance, regard must be had to what interventions make the most difference. There was a lack of a unified approach by staff who sometimes worked in silos and there was a clear need for operational and medical managers to share meetings, agendas and approaches to issues in a more coordinated way.
- Although some changes have been made, unless this progress is consciously fostered and supported, there is a risk that time pressures may lead to a failure to follow through.
- The Inquiry noted the extensive range of very detailed governance information presented at the SMT weekly governance meeting and considers that, whilst

[29] See Report at WIT-00507 to WIT-00567

this meeting was a positive development when introduced, managing this effectively would provide a challenge to any organisation.

- There were large numbers of audits and investigation reports provided at this meeting, however there was no clear, prioritised overall programme of transformation.
- The Inquiry was concerned to find an absence of routine, reliable data to guide decision-making and oversight. Such data is essential for assurance regarding quality of care and basic administration processes. The need for accurate, timely and relevant data to assist in providing signals of emerging issues is a real one for most healthcare systems.
- There appeared to be no real agreed way of looking at patient safety from the perspective of both past harm and current assurance. Systems that are known to assure high standards and high-quality care were either absent or not being used effectively. Regular data can often clarify basic operational issues in departments and can be used to drive improvement at a very basic level, but this was not clearly evident.

Comment

49. The Inquiry noted that the Trust has shown a commitment to improvement of processes and systems. Following the work of the ERG the Trust recognises the need to place a clearer focus on transformation. This should be further developed as part of a regular review of the effectiveness of governance and interventions related to culture. The analytical framework referenced as part of the ERG work should be used to achieve this.

50. The use of data and information to drive decision making in an open and transparent way is a challenge for many organisations and was underdeveloped at the Trust. The Inquiry noted that the ERG expressed the need for refinement in the use of data. This resulted in the CEO highlighting the need for a data strategy.

51. The Inquiry considers that the Trust has identified the need for improvements and has implemented many of them. There is further work to do to link all improvements and strategies into a clear, prioritised programme of organisational improvement and transformation that can be reviewed and challenged over time. The improvements made in the management of SAIs were noted, as was the new Northern Ireland framework which is still in consultation. This framework will greatly assist in setting the tone for a better process in Northern Ireland and in the Trust. Furthermore, the recent Northern Ireland mandate to create Trust Patient Safety and Quality Committees, (referred to above) which will largely cover the work currently undertaken by Trust Governance Committees is commended. It presents a further opportunity to ensure the work of Board Committees is sufficiently reinforced in terms of providing assurance regarding the quality of services.

Recommendations

52. The Inquiry recommends a programme of work by the Trust to:

- Consolidate governance improvements into a clear, prioritised programme overseen by the Board. This will ensure that the large number of improvement plans do not become overwhelming or get lost due to time pressure.
- Develop a comprehensive data and information strategy to support assurance, learning and decision-making.
- Streamline its governance forums to ensure that information presented leads to action and improvement.

A revised programme of work led by the Board and SMT at the Trust should include:

- Agreement regarding an ongoing way of assessing governance effectiveness.
- Identification of any current gaps in assurance.
- An agreed approach to developing a high-quality data and information function to use relevant and timely data to help manage and assure standards of care

and drive decision making. This would not only shine a light on areas that need improvement but also on those areas where there is good assurance and standards are high.

- The Inquiry recommends the development of a data and information strategy with clear aims and ambitions to cover the provision of assurance and learning to improve. Such a strategy requires broad input and expertise. It could usefully encompass a specific focus on developing agreed patient safety and quality standards.
- There is a need to re-evaluate the weekly SMT governance meeting and consider how it could be streamlined. This meeting was set up to increase the oversight of key quality and safety issues and to share learning across directorates. The breadth and depth of information shared is significant, but the Inquiry considers that there could be clearer links between the audits, investigations shared at this meeting and agreed improvement initiatives. The idea of a need for a transformation manager came out of Trust learning from the Inquiry and the post was supported by the Board. As this role is advanced it could usefully help to bring initiatives together.

The opportunity presented by the relatively manageable region of Northern Ireland and the recently introduced patient record management system, 'encompass', provides a significant opportunity to develop a regional approach in this area. The Inquiry considers that:

- The Department should take the opportunity to develop a regional information strategy. In the meantime, Trusts should be supported to incrementally improve their information systems in a way that sustains governance and decision making generally across the system.
- The Department should consider how safety issues that cross organisational divides could be overseen in the future. For example, in the prescription of drugs.
- The Department and Trusts should agree where decisions can be made regarding the kind of data required to provide assurance or signal problems. This would allow appropriate safeguards to be put in place.

5. Serious Adverse Incidents

Background

53. The purpose of investigation of SAIs, whether one that results in actual harm or in the potential for harm, is to provide timely learning for Trusts and staff and to prevent the likelihood of similar incidents occurring again.

What we found

54. The Inquiry identified significant shortcomings in the management of SAIs in the Trust. The Inquiry found cause to criticise a number of aspects of its management of incidents. We recognised that there have been recent improvements in many areas. These included the development of a new policy, mandating a much-improved process of involving patients and families and ensuring more rapid learning.

Recommendations

55. The new Northern Ireland framework which, at the time of writing, is still in consultation form will greatly assist in setting the tone for a better process in Northern Ireland and will need to be incorporated in the Trust. The Inquiry considers that the new framework for learning and improvement from patient safety incidents brings in many required improvements building on the work of the Regulation and Quality Improvement Authority (RQIA) in relation to SAIs. It encompasses learning and recommendations from previous Inquiries as well as those from this Inquiry. The introduction to the framework also sets out context, understanding that successful implementation depends on governance and culture in organisations.

56. The Inquiry is of the view that the emphasis in the new framework sets an important tone and expectation for learning from failures in healthcare. It highlights openness, system-wide learning, cultural change, meaningful engagement with patients, families and staff, and in particular, the importance of

prioritising rapid learning over blame. This is a much-needed positive development.

57. Importantly, the framework consultation document refers to the fact that the framework will form part of "a wider policy agenda to support an Open, Just and Learning Culture"[30] and considers that setting this out at Department and system level is important and supports a commitment to act as is further evidenced by the other recent regional documents referred to above.

58. We recommend that:

- The new SAI framework is fully implemented by the Department. There should be regional support for those leading the improvement in the serious incident processes in each Trust. This involves ongoing feedback and backing for Trusts in terms of making the best use of the new framework and training staff to understand it. Departmental regional support for this training would be helpful. This could take the form of multidisciplinary working groups where illustrative case studies could be used to demonstrate best practice and to discuss queries.
- There should be shared knowledge across Trusts and greater use of inter-Trust investigation leads and other mechanisms for sharing expertise.
- The emphasis of the new framework must be on rapid learning, patient involvement, and system-wide sharing of learning rather than blame.
- The Trust should use the platform provided by the Northern Ireland framework to refresh its approach to incident management. Areas for attention include the use of the current incident reporting system, the weekly incident meeting, and the clarification of responsibilities for completing the agreed learning and actions.

30 Department of Health, "Serious Adverse Incident Redesign Programme Framework for learning and Improvement from Patient Safety Incidents", Consultation Document (March 2025). At: https://www.health-ni.gov.uk/sites/default/files/2025-06/Framework%20for%20Learning%20and%20Improvement%20from%20Patient%20Safety%20Incidents%20-%20Consultation%20document.pdf

- The Trust should continue to improve Board oversight of SAIs and continue thematic reporting of incidents. This reporting should be further developed to ensure that Trust-wide programmes of improvement and transformation can be supported as needed.
- The Trust should continue to develop its approach to SAIs under the leadership of the Medical Director with input from senior managers in governance.
- The Trust should ensure all staff complete a mandatory programme of training that emphasises the primacy of patient safety, as well as learning from error in a way that can be understood and maintained by all staff. While clinical staff have a clear professional duty to report risks to safety, other staff need to understand they too have such a duty.

6. Medical leadership and management of doctors in difficulty

Background

59. Medical leadership is vital for clinical engagement and service improvement aimed at providing high quality safe care. The development of medical leadership in an organisation requires long-term commitment and ongoing investment. Medical leaders should understand and support a variety of tools used to support doctors in difficulty. Failure to address transgressive behaviour in medical staff can lead to failures in teamwork and create a risk to patient safety.

What we found

- There were significant problems in medical management and leadership in the Trust.
- These problems spanned a range of issues including:
  - insufficient time allocated to medical managers;
  - insufficient support staff for medical managers;
  - a lack of cohesion between operational and medical managers that impacted on clear decision making;
  - lack of training and ongoing development; and

- insufficient support for the Medical Director as the most senior medical manager in the Trust.

- Best practice standards for job planning, appraisal and the management of doctors in difficulty were not overseen or embedded and therefore not fully utilised.

Comment

60. The challenging area of managing doctors in difficulty has been commented on throughout this Report. The Inquiry considers that it is this area which illustrates the problems with medical management and leadership most clearly. All of the problems were recognised by the medical managers who gave evidence.

61. A range of improvements have been put in place to strengthen the medical management and leadership processes in the Trust and some are still in development. There have also been improvements in relation to the awareness of and support for managing doctors in difficulty. The Department's working group on MHPS has reported. Further work is needed to embed and advance all aspects of medical management and leadership and for supporting doctors in difficulty.

Recommendations

62. Leadership development in the health service is of critical importance, and there are a variety of approaches to creating better leaders. If development is to be effectively achieved, then leadership training of the medical workforce needs to be specifically and sustainably funded, implemented and evaluated, so that the full benefits can be realised.

63. The Inquiry recommends that:

- There must be sustained investment in leadership development for doctors at all career stages. Improvements discussed in the Medical Management and Leadership chapter should continue. The Department should establish a

dedicated regional programme to strengthen medical leadership and management. This programme should focus on all aspects of medical management and leadership; aid continuous development and provide opportunities for ongoing challenge.

- The Trust should continue to develop its medical managers and leaders ensuring that roles and responsibilities are clear and there is sufficient time allocated to perform the roles.
- Within the Trust there must also be access to ongoing training and development for all medical leaders. Leadership programmes for all doctors, medical managers and clinical leaders must be developed and sustained. Such programmes should be clearly linked to wider organisational development programmes to foster shared decision making across professional boundaries.
- The work done in relation to improving understanding of the different approaches to managing doctors in difficulty and the wider training on the MHPS framework put in place at the Trust should continue.
- While the MHPS framework exists in its current form, the Trust should consolidate the work undertaken to date and develop a protocol to address the recommendations listed at the end of the MHPS chapter.
- The work relating to redevelopment of the MHPS framework in Northern Ireland carried out by the Department should continue at pace as it is long overdue. The Inquiry endorses the recommendations made by the Department's review group, advocating a completely new approach to replace the MHPS framework.
- The Department should continue to invest in and enhance regional working groups for Medical Directors and other senior medical managers. These groups should provide expertise in relation to mechanisms for dealing with doctors in difficulty and difficult doctors. The groups can share case studies and best practice. The remit of these groups should include an emphasis on the use of external resources such as Practitioner Performance Advice (PPA), as well as how to develop and use robust internal processes. Such processes must encompass the need for any necessary support for practitioners,

integrate with and link to all current processes that relate to how concerns about medical staff are addressed.

- All doctors and doctors in training need to be made aware of current processes and receive mandatory training in this area.
- Doctors must be involved in the management and leadership of services and in strategic planning for the future. There must be targeted funding and oversight from the Department. In the interim the Trust must ensure its medical staff is involved in the management and leadership of its services.

7. Urology and Cancer Services

Background

64. This Inquiry came about as a result of the Trust's notification of concerns regarding the work of a single practitioner in its urology service and by the finding that patients had come to harm. The SAIs that led to the Inquiry related to the care of patients with urological cancer. The Trust, supported by the Department, devised a lookback process to identify any further possible harm to patients. At the same time, arrangements were put in place to ensure that the Urology Department received increased management and leadership support and professional oversight. In addition, the specific issues identified relating to the interface between the Urology Service and Cancer Services were addressed. The Urology Service was one department in the Acute Directorate. There was immediate recognition that governance procedures in that directorate and more generally across the Trust needed improvement.

What we found

- The Urology Service struggled to provide the level and quality of service that it would have liked due to an increasing gap between demand for service and the capacity to deliver it. There were pressures on all aspects of the service. Although the demand/capacity gap is a general problem across the Trust and regionally, the problems were particularly evident in urology, resulting in long waiting lists for outpatient appointments and procedures.

- Urology clinicians were committed to providing excellent clinical care; however, they did not always work together as a team to resolve any differences of opinion.
- Medical leadership arrangements relating to urology were not sufficiently clear or well developed.
- There was poor use of data to support meetings within the service and there was insufficient focus on quality and safety at the expense of ministerial targets.
- Operational and medical managers in urology did not work effectively together to resolve problems relating to quality of care or to address issues relating to transgressive behaviour.
- Responsibility for improvement after SAIs was unclear.
- There was a disconnect between Cancer Services and the Urology Service. Cancer Services did not oversee the quality of care for cancer patients in the Urology Service, nor was there shared responsibility for continuous improvement and strategic development of cancer care in urology.
- Integrated oversight of cancer care at Board and Directorate level was not adequate.
- There was unclear development of shared operational, medical and nursing leadership of Cancer Services.

65. The Inquiry recognises the substantial work already undertaken to address the specific issues identified in urology and Cancer Services. The Trust has identified and acted on the need for improvements in governance, medical leadership and organisational development relating to culture. The Trust also invested in specific medical leadership provision for urology to assist necessary improvement. Increased support for audit and the urology department patient safety meeting was put in place. The improvement plans included general improvements to cancer multidisciplinary teams (MDTs). However, ongoing leadership support, workforce stabilisation and improved data use remain essential.

Recommendations: Urology

66. The impact of the Inquiry on the Urology Department has been very significant. The Inquiry recommends that the Urology Service be provided with ongoing specific medical and operational leadership support from Senior Management, the Board and the Department. This will allow for stabilisation and help to rebuild the confidence of patients, the public and staff. The Inquiry considers that using the Urology Service to test improvement initiatives, for example in the area of data and information, might be of benefit to the wider Trust. Moreover, it may help boost morale in the service by allowing it to present as a proactive high-quality service at the forefront of developments for urology services in Northern Ireland. The Inquiry recommends that in providing that support, senior management, the Board and Department should consider the following:

- The recruitment of a stable consultant workforce is a priority. The Department must develop a clear strategic plan for urology services at the Trust and in Northern Ireland more generally. The problems in recruitment in urology should be considered more broadly as part of the general problems with recruiting consultant medical staff in Northern Ireland. The Inquiry considers that there is merit in setting up a specific project relating to the recruitment and retention of medical staff as part of workforce planning functions in the Department. While we recognise that there are problems relating to this in many areas across the UK, some Trusts have been successful in recruiting and retaining the expertise required. Novel solutions tailored to the situation are required. The Department and Trust should learn from what has succeeded elsewhere.
- The urology team and medical leaders should be given the time and resource to continue to participate in and contribute to Northern Ireland wide working groups to develop plans for the delivery of services. This support should include the implementation of the Getting it Right First Time (GIRFT) review.
- Methods for communicating with patients on waiting lists should be tested in the Trust's Urology Service. A working group should be set up to advise on how the following areas can be addressed:

a. The new encompass system allows greater information to be provided to patients however patients require explanations and information that is not necessarily on the system. Possible ways of improving how patients can access information relating to appointments, investigations and procedures and/or access advice relating to their condition should be tested in urology before being rolled out across the Trust and regionally.

b. In addition, some patients may deteriorate and come to harm while on waiting lists. Methods of assessing and mitigating this through reprioritisation should be tested in the Urology Service at the Trust and then considered on a regional basis.

- Data sets of information for meetings should also be tested in the Urology Department alongside the improved support for audit already in place. This could then be used as a model for other services.

Recommendations: Cancer Services

67. The Trust has worked through a detailed action plan relating to Cancer Services, specifically in relation to the oversight and support for MDTs and has addressed the issues identified in the SAIs in urology. Extending the work to include dimensions of quality, safety and strategic planning in Cancer Services would be of benefit. The Trust has understood the need for further improvements in the management and leadership of Cancer Services and has recently told the Inquiry that they have created a new senior manager role. This role includes overseeing safety and quality and bringing oversight of Cancer Services into a quarterly strategic Cancer Board. The Inquiry recommends that the Trust consolidates all current work into a project led by SMT to consider the following:

- Development of the medical leadership of Cancer Services at the Trust so that there is a more strategic view of the delivery of services for patients with cancer, including an emphasis on quality standards and strategic planning for the service.
- The Department and Trust should devise a programme to support the key role of nurses in cancer care and to develop senior cancer nurse leadership as

part of the leadership team in Cancer Services. This should be done both at Trust level and regionally.

- Cancer Services should be led by a formal triumvirate comprising a senior manager, a doctor and a nurse who would share decisions. The Inquiry considers that this style of coordinated triumvirate leadership would be beneficial across the Trust. We recognise that nurses already make very significant contributions in leadership roles and could significantly enhance management structures. Development of this type of triumvirate of clinical leadership should be added to the overall project on medical management and leadership led by the Medical Director.
- To ensure that the Board is fully aware of the risks to quality care and plans to mitigate these, Board committees should receive regular reports on the service. These reports should bring operational performance, quality and strategy together to enable informed discussion.
- As the focus on Cancer Services came about because of the SAIs in urology related to patients with cancer, the urology service should be used to test new ways of bringing cancer data together. The data should be integrated in a way that would help staff and patients understand the overall quality of care being provided.

Concluding comments

68. In summary, while the Inquiry recognises that both the Trust and Department have initiated several improvements, ongoing focused action is still required in a number of areas. More work needs to be carried out in respect of patient engagement, culture, leadership, governance, medical management, and specific clinical services to ensure safe, high-quality care in the Trust and more widely throughout Northern Ireland's healthcare system.

- A Northern Ireland system-wide strategy is required to prioritise patient safety as a core healthcare purpose. This strategy should emphasise culture, measurement and patient involvement.

- This strategy should include a specific programme to improve communication with patients, complaint processes, advocacy support and patient involvement in service redesign.
- Organisational development and 'just culture' must be promoted. A culture fostering openness, learning and patient safety as the core aim is essential.
- Ongoing leadership development programmes, including medical leadership, are necessary to support the patient safety agenda and effective delivery of services.
- Governance systems should be underpinned by a significant improvement in data and information systems. Only then can there be assurance as to the reliability and quality of care, or recognition of warning of signals indicating possible problems in care. In this way improvements can be tracked over time.
- The Trust's Urology Service requires ongoing leadership support, workforce stabilisation and inclusion in regional workforce planning to tackle recruitment and capacity issues.

69. The Inquiry asks the Trust and the Department for their commitment to act on the recommendations outlined above and those referred to in the body of the Report.

Appendix 1a

Urology Services Inquiry Questionnaire

Points to assist with completion of the USI Questionnaire

- A helpful **Guide to Completing the USI Questionnaire** is available (see attached) and you are advised to read these guidance notes before attempting to complete this questionnaire.
- This questionnaire will assist the Inquiry to gain information from you regarding your experience of Urology services provided within the Southern Health and Social Care Trust (SHSCT).
- We appreciate that some patients/former patients or their families may have concerns about identifying themselves by name etc on the questionnaire. We would however reassure you that any personal details noted will only be seen by those parties, organisations or the core participants involved in our investigations who need to see it for the purpose of progressing Inquiry business. All core participants must adhere to the terms of our Restriction Orders which are now in place and available to view on our website. The term "core participant" is also defined on our website under the heading "Frequently Asked Questions – FAQ's". Our USI website address is noted below: www.urologyservicesinquiry.org.uk.
- We would encourage you to fill out your personal details as fully as possible in Section A as it will increase the value of the information to our investigative work and may also enhance your potential input to the Inquiry. We would reassure you that your name and personal details will be protected and will be anonymised unless you consent to them being made public. Your personal information will be handled in compliance with the applicable legislation including the Data Protection Act 2018 and the General Data Protection Regulations 2018.
- Please note that it is not the intention of this Inquiry to publish the questionnaires that are submitted to assist us with our work, although the report may refer to some of the content.
- If you require assistance completing this questionnaire please do not hesitate to contact our office directly on telephone number: **028 90251005**.

- The work of this Inquiry is entirely independent of all other organisations including healthcare providers, regulators and government departments.
- Only certain sections of the form will apply to you. We would ask everyone to complete Section A but thereafter please only complete those sections which apply to you.
- When you have completed the relevant sections please complete Section F and then ensure you have signed the completed questionnaire at Section G.

SECTION A – Personal Details

Name	
Address	
Contact Telephone Number	
Mobile Phone Number	
Email Address	
HSC Number (if known)	

	Yes/No
With regard to Section A above, have you read the '**Personal Details**' section of the 'Guide to Completing the USI Questionnaire'?	
Are you completing this questionnaire as a patient/former patient? (If your answer is Yes, go to Section B)	

Are you completing this questionnaire as a relative of a patient/former patient?	
If you are completing this questionnaire as a **relative of a patient/former patient**, do you have the express authority of the patient to engage with the Inquiry and provide information that relates to their care and treatment? (If your answer is Yes, go to Section B)	
If you are completing this questionnaire as **a relative of a deceased patient**, have you discussed providing information concerning the deceased patient with other relatives/former next of kin and no objection is being raised. (If your answer is Yes, go to Section B)	

If you are completing this questionnaire and you are not the patient/former patient or a relative of one please state your role.	

SECTION B – Contact with Urology Services

Please complete the table below setting out details of each occasion when you accessed urology services. Provide details of the dates attended, relevant consultant, hospital/clinic etc and a brief description of the reason for the visit/treatment received. If you cannot remember exact dates then please give approximate dates where possible.

Date(s)	**Seen By** (e.g. name of consultant/healthcare professional)	**Location** (e.g. Craigavon Area Hospital)	**Brief description of reason for visit and/or treatment received**

Continue on a separate sheet if necessary

SECTION C – Details of concerns raised/complaints reported

1.	Please provide full details of any concerns and/or complaints raised by you, specifying the nature of those concerns in as much detail as possible.

2.	Please specify the date when any concern or complaint was raised and if you cannot recall date(s) please try to indicate an approximate timescale.
3.	Please note the name and/or position held of the person you raised any concern with or reported any complaint to at the time.
4.	Please advise for each occasion a concern or complaint was raised whether this was done verbally or in writing (e.g. via letter/email etc).

5.	If your concern or complaint was made in writing, please provide copies of that correspondence if possible.
6.	Please advise if you received any acknowledgment or response (whether a holding response or a detailed response) to your complaint. If so, can you please provide copies?
7.	Please advise the outcome of any concern made or complaint raised by you.

SECTION D - Details of concerns held but NOT raised/reported

1.	Please provide full details of any concerns you held at the relevant time specifying the nature of those concerns in as much detail as possible.
2.	Please explain why you did not raise your concern(s) at the time and state if there was something that prevented you from raising your concern(s).

SECTION E – Personal impact/additional information

Please outline the personal impact that the treatment received, which forms the basis of your complaint(s), has had on the patient/deceased patient and provide any additional information which you feel may be of assistance to this Inquiry.

Additional sheets, if needed, can be attached

SECTION F – Sharing information / Other related reviews

The Inquiry may consider that the information you have provided is more relevant to one of the other organisations carrying out a review or investigation as detailed in the 'Guide to Completing the USI Questionnaire' under the heading 'Other Related Reviews'.

	Yes/No
Would you be content for the Inquiry to share the contents of this questionnaire with other relevant organisations?	
Would you like to discuss this in more detail with the Inquiry before making a decision on the sharing of information?	

SECTION G – Signature

Signed:	
Name in Block Capitals:	
Date:	

SECTION H - Returning your Questionnaire

Please ensure that you have enclosed the following items:

- A fully completed questionnaire.
  (Check the questionnaire has been signed and dated).
- All supporting documentation and/or correspondence.
  (Please provide copies and **NOT** originals of your supporting material).
- If you require additional sheets to complete your responses to this questionnaire, please ensure that they are securely attached.
- If you require assistance completing this questionnaire please do not hesitate to contact our office directly on telephone number: **028 90251005.**

Completed questionnaires can be emailed to evidence@usi.org.uk or returned by post to:-

The Urology Services Inquiry

1st Floor Bradford Court

1 Bradford Court

Belfast

BT8 6RB

Appendix 1b

Urology Services Inquiry

Guide to Completing the Urology Services Inquiry Questionnaire

Volume 4 – Guide to Completing the Urology Services Inquiry Questionnaire

Contents

Background to the work of the Urology Services Inquiry

The Inquiry Chair is Christine Smith KC who is a Senior Barrister, called to the Bar of Northern Ireland in 1985 and took silk in 2011. She is assisted in her task by Dr Sonia Swart, a medical governance expert and Mr Damian Hanbury, a consultant urologist.

The Urology Services Inquiry (USI) commenced its work on 6th September 2021 and now wishes to hear from the public to assist with its investigations. The Inquiry would like to hear in particular from patients and/or their family members regarding concerns or complaints that they may have had in relation to the provision of Urology Services within the Southern Health and Social Care Trust. The remit of our work is set out in detail in the USI Terms of Reference which can be accessed on our website www.urologyservicesinquiry.org.uk

This guide is to assist you in understanding our work and to provide you with the necessary information to make an informed decision on whether or not you wish to complete the USI Questionnaire and how to complete it.

We expect that it will be of interest to patients and/or their families who have availed of these services but we also welcome comment from anyone else who may have had concerns regarding Urology Services whether they brought these concerns to anyone's attention or not. This would include staff or others who worked in or alongside the health service and all those healthcare providers or others connected in any way to the work of urology services within the SHSCT.

The USI inquiry is independent of all other organisations and is inquisitorial in nature.

What this Inquiry is investigating

This inquiry is investigating whether appropriate action was taken in light of the information that was known, or ought to have been known, by those with responsibility for decision making and oversight. Following investigation into this matter the Inquiry intend to issue a report with recommendations and learning points that can be identified.

Our Terms of Reference set out what this Inquiry is investigating in detail but in short the Inquiry is investigating whether the Southern Health and Social Care Trust's handling of complaints or concerns brought to its attention prior to May 2020 were adequate and whether there was anything that should have alerted the Trust to instigate an earlier more thorough investigation. The Inquiry is to evaluate the corporate and clinical governance procedures and arrangements within the Trust and the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant, Mr Aidan O'Brien, for the time period January 2019 to May 2020. Our focus will be on the governance of patient care and safety within the Trust's urology specialty.

It is likely that these investigations will result in the Inquiry reviewing the role and input of other organisations such as the Health and Social Care Board, the Public Health Agency, the Department of Health, the Regulation Quality and Improvement Authority (RQIA) and independent care providers.

What the Inquiry is NOT investigating

- Our Terms of Reference clearly state that this Inquiry is NOT tasked to make decisions on the clinical practice or employment status of Mr Aidan O'Brien. That is a matter for the General Medical Council (GMC) and it would be entirely inappropriate for this Inquiry to encroach on the GMC's remit.
- This Inquiry is NOT responsible for the conduct of the "lookback review" which is the responsibility of the Southern Health and Social Care Trust.

- The Urology Services Inquiry would also like to make it clear that it is NOT involved in any compensation scheme for anyone who may be dissatisfied with the level of Urology service received.

Other related reviews

There are a number of other reviews and investigations currently ongoing and relating to either Urology Services or arising out of the same circumstances which led to the establishment of this Inquiry (e.g. the GMC investigation). Whilst some of the reviews and investigations may overlap with the work of this Inquiry and some of their outcomes may be of interest to the work of this Inquiry at a later stage, the work of this Inquiry is distinct from, and independent of, any other reviews.

Information of relevance from the public

The Inquiry is specifically interested in concerns or complaints raised relating to patient care and safety within Urology Services and it is in this area that we invite input from the public.

How can you assist?

Completing Section A – Personal details

By completing this questionnaire you can greatly assist the work of this Inquiry. We would encourage you to complete all questions that are relevant to you. Section A is a request for personal details. If you are providing information in relation to a deceased relative (or responding on behalf of a patient or relative who cannot for whatever reason reply on their own behalf) you should discuss the position with other relatives and agree in advance that there are no objections to information being shared with this Inquiry. There is a box to tick to confirm that you have the necessary agreement(s) or permission.

Completing Section B – Contact with Urology Services

We have requested details of all contact with Urology Services within the Trust and sought dates of all contact. We would ask that you attempt to give some indication of when you were in contact with Urology Services even if you cannot recall the exact dates of your attendance.

Completing Section C – Details of concerns raised/complaints reported

This section of the questionnaire allows you to provide information relating to any concerns you raised in the past relating to Urology Services. You should complete this section if you raised complaints or concerns regardless of whether you did this formally or informally. Please provide as much information as possible. You can continue on a separate sheet if necessary which you should attach to the questionnaire once completed.

If you hold documentation or can obtain documentation relating to the information you have provided (eg. if you forwarded a letter of complaint or received any response(s) to your complaint(s), please attach a copy of that documentation to your questionnaire. We would ask that you do NOT forward the originals of these documents to the Inquiry at this stage but ensure that you retain them in your possession.

We do not require you to forward your (or your relatives) medical notes and records when you return this questionnaire so please do not send these documents to us.

Completing Section D – Details of concerns held but NOT raised/reported

Even if you did not report your concern(s) or complaint(s) either informally or formally we still want to hear from you if you had concerns but, for whatever reason, failed to raise them at the time. If you fall into this category the Inquiry is particularly keen to understand why the concerns were not raised. We would like to know and to better

understand what led to those concerns not being shared with others. The Inquiry will not judge you for not raising these concerns at the time. We understand that there may have been many reasons for a failure to raise a concern at the time. Please provide as much information as possible and attach any additional sheets to the questionnaire once completed.

Completing Section E – Personal impact/additional information

This Inquiry is very interested to hear how your experience impacted upon you or your relative personally and whilst we appreciate this may be a difficult section to complete we would encourage you to do so as the information provided will greatly assist our work. If you require additional sheets to provide this personal impact statement or any other additional information that you want this Inquiry to consider then please attach these additional sheets to the questionnaire once completed.

Completing Section F – Sharing information/Other related reviews

It is important to explain that there are a number of other reviews and investigations currently ongoing and relating to Urology Services within the Trust or arising out of the same circumstances which led to this Inquiry being established. Whilst some of these reviews or investigations may overlap with the work of this Inquiry and some of their outcomes may be of interest to our work at a later stage, the work of this Inquiry is distinct from and entirely independent of other reviews.

Completing Section G – Signature

We would ask you to ensure that you have signed and dated the questionnaire when completed. Please also ensure that you print your name in block capitals so that we can ensure we have your correct details on our records.

Completing Section H - Returning your questionnaire

Completed questionnaires can be emailed to evidence@usi.org.uk or returned by post to:-

The Urology Services Inquiry

1st Floor Bradford Court

1 Bradford Court

Belfast

BT8 6RB

Relevant USI documents

The following documents are available on the Inquiry website www.urologyservicesinquiry.org.uk which you may find of assistance in advance of completing this questionnaire:

- Terms of Reference
- Frequently Asked Questions
- Privacy Notice

Contact details – help and support

We appreciate that completing this questionnaire may be a difficult task for some and we are happy to help in any way we can to assist with its completion.

If help and support is required please do not hesitate to contact us directly either by email at info@usi.org.uk or on our contact telephone number 028 90251141.

Appendix 2

Inquiry Costs

Year of Expenditure	Total £ (rounded)
2021/22	892,535
2022/23	2,600,311
2023/24	2,696,526
2024/25	1,514,834
2025/26	1,341,511
2026/27 (estimated)*	528,000
Total	**9,573,717**

* Final costs for 2026/27 will be published when available.

Appendix 3

Core Participants and their Legal Representatives

Name	Solicitor	Counsel
Mr Aidan O'Brien	**Tughans Solicitors** Andrew Anthony Kevin Hegarty Aimee Crilly	Gerry Boyle KC Robert Millar BL
Southern Health and Social Care Trust	**DLS** Avril Frizell Emmet Fox Caitlin Turnbull Jenny Gibson Keeva Wilson	Donal Lunny KC Michael McGarvey BL Jonathan Park BL Alana Harty BL Elizabeth Ferguson BL Samatha Madden BL
Department of Health	**DSO** Eugene O'Loan Caroline Cooley Chris Mitchell Claire Demelas Mairead McDowell Sara Erwin Sarah Wilson Tutu Ogle Catherine Cairns	Philip Henry KC David Reid BL Leona Gillen BL

Appendix 4

Persons who provided Witness Statements

Name	Position (relevant to the Inquiry)	Bates Reference
Ahmed Khan	MHPS Case Manager and Acting Medical Director	WIT-31049 to WIT-32234 WIT-91924 to WIT-91936
Aidan Dawson	Chief Executive, Public Health Authority	WIT-61559 to WIT-61963 WIT-106837 to WIT-106874
Aidan O'Brien	Consultant Urologist	WIT-82373 to WIT-84134 WIT-98807 to WIT-98808 WIT-107564 to WIT-107623 WIT-107947 to WIT-107947
Ajay Pahuja	Consultant Urologist	WIT-59635 to WIT-59708
Aldrina Magwood	Director of Performance & Reform	WIT-35901 to WIT-37460 WIT-96706 to WIT-96713
Ali Thwaini	3fivetwo Healthcare	WIT-108028 to WIT-108058
Angela Muldrew	Cancer Services Co-ordinator	WIT-88295 to WIT-88478
Anita Carroll	Assistant Director for Functional Support Services	WIT-21227 to WIT-23344 WIT-96828 to WIT-96843
Ann Turkington	Cancer Tracker/MDT Co-ordinator	WIT-87566 to WIT-87615
Anne McVey	Assistant Director of Acute Services	WIT-20170 to WIT-21076 WIT-99673 to WIT-99750
Anne Quinn	Head of Clinical Audit and Morbidity and Mortality	WIT-91051 to WIT-91861
Anthony Glackin	Consultant Urologist	WIT-42256 to WIT-42354 WIT-57924 to WIT-57928 WIT-100352 to WIT-100353
Barry Conway	Assistant Director Cancer and Clinical Services	WIT-23798 to WIT-24499
Briege Donaghy	Chief Executive, The Regulation & Quality Improvement Authority	WIT-105976 to WIT-106614 WIT-106891 to WIT-107048
Catherine Glenny	Cancer Tracker/MDT Co-ordinator	WIT-60755 to WIT-60838

Volume 4 - Persons who provided Witness Statements

Name	Position (relevant to the Inquiry)	Bates Reference
Charles McAllister	Associate Medical Director for Surgery (April to October 2016)	WIT-14838 to WIT-14893 WIT-103733 to WIT-103792
Christopher Hagan	Consultant Urologist, BHSCT	WIT-98833 to WIT-99147 WIT-100349 to WIT-100351
Christopher Wamsley	Acute Clinical and Social Care Governance Co-ordinator	WIT-63200 to WIT-66156
Colin Fitzpatrick	Adviser, Practitioner Performance Advice (formerly NCAS)	WIT-53474 to WIT-53828 WIT-62772 to WIT-63063 WIT-91049 to WIT-91050
Colin Weir	Clinical Director in Urology, ENT and General Surgery (June 2016 - December 2018)	WIT-19882 to WIT-20069
Colm Donaghy	Chief Executive of SHSCT (April 2007 to August 2009)	WIT-15130 to WIT-15395
Darren Mitchell	Consultant Clinical Oncologist, BHSCT	WIT-96652 to WIT-96705
David Cardwell	Clinical Governance Manager	WIT-99148 to WIT-99672 WIT-100354 to WIT-100366
David Connolly	Consultant Urologist	WIT-41945 to WIT-41997 WIT-42166 to WIT-42170
David Gracey	Consultant Radiologist; Acting Clinical Director for Radiology (June 2015 to December 2017)	WIT-89441 to WIT-90015
David Stewart	Consultant Clinical Oncologist, BHSCT	WIT-106820 to WIT-106836
Debbie Burns	Director of Acute Services (2013 to 2015)	WIT-96848 to WIT-98538
Dermot Hughes	Independent Chair of the Serious Adverse Incident Review 2020	WIT-84135 to WIT-85745
Eamon Mackle	Associate Medical Director for Surgery and Elective Care (2008 to 2016)	WIT-11718 to WIT-11972 WIT-14757 to WIT-14796
Eileen Mullan	Non-Executive Director of SHSCT Board (2016 to November 2020); Non-Executive Chair of SHSCT Board (from December 2020)	WIT-100419 to WIT-103265
Emma Stinson	Personal Assistant to the Director of Acute Services 2010-2021	WIT-59772 to WIT-60263
Esther Gishkori	Director of Acute Services (August 2015 to June 2020)	WIT-23345 to WIT-23412

Name	Position (relevant to the Inquiry)	Bates Reference
Fiona Reddick	Head of Cancer Services	WIT-90987 to WIT-91048 WIT-94649 to WIT-94666
Fionnuala Houghton	Consultant Clinical Oncologist, BHSCT	WIT-105820 to WIT-105835
Francis Rice	Director of Mental Health and Disability Services / Executive Director of Nursing and Allied Health Professions (2007 to March 2016); Interim Chief Executive (April 2016 to March 2018)	WIT-17946 to WIT-18406
Gillian Rankin	Interim Director of Acute Services (from December 2009); Director of Acute Services (March 2011 to March 2013)	WIT-15758 to WIT-17488 WIT-96714 to WIT-96750
Grainne Lynn	Adviser, Practitioner Performance Advice (formerly NCAS)	WIT-53447 to WIT-53473
Griania White	Cancer Tracker/MDT Co-ordinator	WIT-61513 to WIT-61558
Heather Trouton	Assistant Director for Surgery and Elective Care (October 2009 to March 2016)	WIT-11973 to WIT-13066 WIT-14797 to WIT-14837 WIT-91881 to WIT-91882
Helen Forde	Head of Health Records (October 2009 to December 2020)	WIT-61152 to WIT-61512 WIT-107951 to WIT-107995
Helen Walker	Former Assistant Director for HR	WIT-91862 to WIT-91874
Hilda Shannon	Cancer Tracker/MDT Co-ordinator	WIT-60602 to WIT-60692
Hugh Gilbert	Urology representative on the Royal College of Surgeons Invited Review Mechanism (IRM) acquired to provide an expert opinion for the Serious Adverse Incident Review 2020	WIT-85873 to WIT-85893 WIT-98539 to WIT-98543 WIT-98809 to WIT-98832
Ian Menown	Consultant Cardiologist	WIT-107996 to WIT-108009
Jason Young	Clinical Charge Nurse	WIT-81622 to WIT-81705
Jennifer McMahon	Urology Clinical Nurse Specialist	WIT-81187 to WIT-81621 WIT-96751 to WIT-96806
John Paul O'Donoghue	Consultant Urologist	WIT-50496 to WIT-50692 WIT-103266 to WIT-103269
John Simpson	Medical Director (August 2011 to July 2015)	WIT-25675 to WIT-26077 WIT-103273 to WIT-103532 WIT-105748 to WIT-105759

Name	Position (relevant to the Inquiry)	Bates Reference
John Wilkinson	Non-Executive Director on the Board	WIT-26078 to WIT-26125 WIT-91941 to WIT-91942
Jonathan McAleese	Consultant Clinical Oncologist, BHSCT	WIT-105760 to WIT-105819
Joseph O'Sullivan	Consultant Clinical Oncologist, BHSCT	WIT-96638 to WIT-96651
Kate O'Neill	Urology Clinical Nurse Specialist	WIT-80877 to WIT-81186 WIT-94681 to WIT-94909
Katherine Robinson	Head of Acute Referral and Booking Centre and Secretarial Admin	WIT-60347 to WIT-60601 WIT-91999 to WIT-91999
Kingsbridge Healthcare Group (3fivetwo)	As part of a waiting list initiative work was outsourced to 3fivetwo Healthcare by the SHSCT	WIT-108010 to WIT-108027
Kuo Jong Ho	Locum Consultant Urologist (October 2011 to August 2012)	WIT-59709 to WIT-59771
Leanne McCourt	Urology Clinical Nurse Specialist	WIT-85894 to WIT-86620 WIT-94679 to WIT-94680
Lucy Jellett	Locum Oncology Consultant	WIT-106875 to WIT-106890
Lynne Hainey	Acting Human Resources Manager (July 2014 to August 2017)	WIT-14894 to WIT-15129
Mairead McAlinden	Acting Chief Executive of SHSCT (from September 2009; Chief Executive of SHSCT (November 2010 to March 2015)	WIT-18538 to WIT-19881
Marc Williams	Consultant Radiologist; Lead Radiologist to the Urology MDT	WIT-60264 to WIT-60346
Margaret Marshall	Assistant Director of Clinical and Social Care Governance	WIT-87114 to WIT-87424
Maria O'Kane	Medical Director (December 2018 to April 2022); Temporary Accounting Officer (from January 2019); Interim Chief Executive of SHSCT (from Feb 2022); Chief Executive of the SHSCT (May 2022 to January 2025)	WIT-04462 to WIT-11717 WIT-20070 to WIT-20169 WIT-44934 to WIT-50310 WIT-55874 to WIT-57923 WIT-57929 to WIT-59634 WIT-90980 to WIT-90984 WIT-91943 to WIT-91960
Marie Dabbous	Cancer Tracker/MDT Co-ordinator	WIT-60693 to WIT-60754
Mark Haynes	Consultant Urologist	WIT-53839 to WIT-55873 WIT-103793 to WIT-104211

Name	Position (relevant to the Inquiry)	Bates Reference
Martina Corrigan	Head of Service for ENT and Urology	WIT-26126 to WIT-31048 WIT-39865 to WIT-40944 WIT-40945 to WIT-40950 WIT-41803 to WIT-41807 WIT-94926 to WIT-94952 WIT-98544 to WIT-98770
Mary Burke	Interim Assistant Director of Unscheduled Care (from September 2020)	WIT-24500 to WIT-25674
Matthew Tyson	Consultant Urologist	WIT-42171 to WIT-42255 WIT-104212 to WIT-104214
Meadhbha Monaghan	Chief Executive, Patient & Client Council	WIT-106617 to WIT-106749
Mehmood Akhtar	Consultant Urologist (2007 to 2012)	WIT-41808 to WIT-41944
Melanie McClements	Director of Acute Services	WIT-34103 to WIT-35900 WIT-96844 to WIT-96847
Michael Young	Consultant Urologist & Clinical Lead	WIT-51661 to WIT-53435 WIT-103590 to WIT-103732 WIT-104215 to WIT-104223
Neta Chada	Case Investigator under the MHPS Framework	WIT-23748 to WIT-23797 WIT-91937 to WIT-91940
Noleen Elliott	Aidan O'Brien's Secretary	WIT-76305 to WIT-77974 WIT-91961 to WIT-91998 WIT-96807 to WIT-96808
Patricia Kingsnorth	Acting Clinical & Social Care Governance Co-ordinator	WIT-92000 to WIT-94640 WIT-96809 to WIT-96827
Patricia Thompson	Urology Clinical Nurse Specialist	WIT-86621 to WIT-86880
Patrick Loughran	Medical Director (March 2007 to July 2011)	WIT-15396 to WIT-15453 WIT-105934 to WIT-105946
Paul Cavanagh	Director of Hospital Care within the Department of Health's Strategic Planning and Performance Group	WIT-104224 to WIT-105747
Paula Clarke	Interim Chief Executive of SHSCT and Accountable Officer (April 2015 to March 2016)	WIT-33577 to WIT-33893 WIT-37461 to WIT-39864

Name	Position (relevant to the Inquiry)	Bates Reference
Pauline Leeson	Non-Executive Director	WIT-99751 to WIT-100348 WIT-105930 to WIT-105933
Peter May	Permanent Secretary, Department of Health from April 2022	WIT-42355 to WIT-44933 WIT-85746 to WIT-85872 WIT-107049 to WIT-107563 WIT-107624 to WIT-107946 WIT-107948 to WIT-107950
Poh Lin Shum	Consultant Clinical Oncologist, BHSCT	WIT-106750 to WIT-106762
Rachel McCartney	Cancer Tracker/MDT Co-ordinator	WIT-87526 to WIT-87565
Ram Suresh	Consultant Urologist	WIT-50311 to WIT-50495 WIT-103270 to WIT-103272
Richard Pengelly	Permanent Secretary, Department of Health (July 2014 to April 2022)	WIT-105879 to WIT-105929
Richard Wright	Medical Director (July 2015 to August 2018)	WIT-17809 to WIT-17945 WIT-18407 to WIT-18537 WIT-91875 to WIT-91880
Roberta Brownlee	Chair of SHSCT Board (2011 to 2020)	WIT-90818 to WIT-90979 WIT-105947 to WIT-105975 WIT-106615 to WIT-106616
Robin Brown	Consultant General Surgeon; Clinical Director for Surgery and Elective Care (January 2008 to March 2016 with responsibility for Urology from January 2008 to September 2010 only)	WIT-17489 to WIT-17808 WIT-100409 to WIT-100418 WIT-103533 to WIT-103589
Ronan Carroll	Assistant Director for ATICS & SEC	WIT-13067 to WIT-14756 WIT-21099 to WIT-21140 WIT-91919 to WIT-91920 WIT-94953 to WIT-94965 WIT-98771 to WIT-98806
Russell Houston	Consultant Clinical Oncologist, BHSCT (1988 to 2016) Clinical Director of Oncology, BHSCT (1993 to 2009)	WIT-105836 to WIT-105848
Ryan Wilson	Director of Secondary Care, Department of Health	WIT-50693 to WIT-51660 WIT-87425 to WIT-87525
Samuel Hall	Consultant ENT; Clinical Director of Surgery (2011 to 2016)	WIT-40951 to WIT-40992

Name	Position (relevant to the Inquiry)	Bates Reference
Sandra Judt	Board Assurance Manager	WIT-61964 to WIT-62771
Sarah Moore	Cancer Tracker	WIT-86881 to WIT-86936
Sarah Ward	Lead Nurse, Surgery and Elective Care (March 2019 to November 2021); Head of Service for Urology Lookback Review	WIT-88479 to WIT-89440
Seamus McAleer	Consultant Clinical Oncologist, BHSCT	WIT-105849 to WIT-105865
Shane Devlin	Chief Executive of the SHSCT (December 2018 to February 2022)	WIT-00001 to WIT-04461 WIT-21141 to WIT-21226 WIT-90985 to WIT-90986
Sharon Gallagher	Deputy Secretary, of the Department of Health's Strategic Planning and Performance Group	WIT-66157 to WIT-75711
Sharon Glenny	Operational Support Lead	WIT-81706 to WIT-82372 WIT-94966 to WIT-95180
Shauna McVeigh	Cancer Tracker/MDT Co-ordinator	WIT-63064 to WIT-63199 WIT-105866 to WIT-105878
Simon Gibson	Assistant Director for Surgery & Elective Care (April 2007 to September 2009); Assistant Director, Medical Director's Office (from April 2016)	WIT-23413 to WIT-23747 WIT-33894 to WIT-34102
Sinead Lee	Cancer Tracker/MDT Co-ordinator	WIT-75712 to WIT-76304
Siobhan Hynds	Employee Relations Manager (2011 to January 2016) Head of Employee Relations (February 2016 to 2018) Deputy Director of HR Services (from 2019)	WIT-41998 to WIT-42165 WIT-91921 to WIT-91923
Stephen McNally	Director of Finance; Acting Chief Executive (January to July 2017 and November 2017 to March 2018)	WIT-15454 to WIT-15703 WIT-21077 to WIT-21098
Stephen Wallace	Assistant Director of Systems Assurance	WIT-77975 to WIT-80876
Steve Evans	Senior Adviser, Practitioner Performance Advice (formerly NCAS)	WIT-53829 to WIT-53838 WIT-53436 to WIT-53446
Suneil Jain	Consultant Clinical Oncologist, BHSCT	WIT-106784 to WIT-106819

Name	Position (relevant to the Inquiry)	Bates Reference
Ted McNaboe	Clinical Director for ENT and Urology (December 2018 to March 2020 and November 2020 to December 2021); Interim Divisional Medical Director for Surgery and Elective Care (from December 2021)	WIT-15704 to WIT-15757
Tony Stevens	Medical Director, BHSCT(2006 to 2014); Chief Executive and Accounting Officer, NHSCT (2014 to 2020)	WIT-106763 to WIT-106783
Tracey Boyce	Director of Pharmacy & Medicines Management	WIT-87616 to WIT-88294 WIT-96617 to WIT-96637
Trudy Reid	Acute Governance Coordinator	WIT-95181 to WIT-96616 WIT-100367 to WIT-100408
Vicki Graham	Cancer Services Co-ordinator	WIT-60839 to WIT-61151 WIT-94667 to WIT-94678
Vivienne Toal	Director of HR & Organisational Development	WIT-40993 to WIT-41802 WIT-91883 to WIT-91918
Wendy Clayton	Interim Head of Service for ENT, Urology, Ophthalmology & Outpatients	WIT-32235 to WIT-33576
Wendy Kelly	Cancer Tracker/MDT Co-ordinator	WIT-86937 to WIT-87113
Zoe Parks	Head of Medical HR	WIT-90016 to WIT-90817 WIT-94910 to WIT-94925

Appendix 5

Witnesses who gave oral evidence

Name	Hearing Date
Peter May	15 Nov 2022 09 Apr 2024
Ryan Wilson	15 Nov 2022
Mark Haynes	16 Nov 2022 17 Nov 2022 01 Dec 2022 22 Feb 2024
Dermot Hughes	29 Nov 2022 30 Nov 2022 25 Jan 2023
Hugh Gilbert	29 Nov 2022 30 Nov 2022 25 Jan 2023
Maria O'Kane	06 Dec 2022 12 Mar 2024 13 Mar 2024 14 Mar 2024
Shane Devlin	07 Dec 2022 08 Dec 2022
Eamon Mackle	26 Jan 2023 31 Jan 2023
Heather Trouton	31 Jan 2023 01 Feb 2023
Richard Wright	02 Feb 2023 28 Feb 2023
Colin Weir	21 Feb 2023
Charles McAllister	21 Feb 2023

Name	Hearing Date
Simon Gibson	22 Feb 2023
Martina Corrigan	23 Feb 2023 28 Jun 2023 29 Jun 2023
Esther Gishkori	23 Feb 2023 14 Jun 2023 15 Jun 2023
Vivienne Toal	01 Mar 2023 02 Mar 2023
Ronan Carroll	02 Mar 2023
Neta Chada	21 Mar 2023 29 Mar 2023
Siobhan Hynds	22 Mar 2023
Ahmed Khan	23 Mar 2023 28 Mar 2023
John Wilkinson	29 Mar 2023
Colin Fitzpatrick	30 Mar 2023
Grainne Lynn	30 Mar 2023
Ronan Carroll	18 Apr 2023
Aidan O'Brien	19 Apr 2023 20 Apr 2023 21 Apr 2023 08 Apr 2024 10 Apr 2024 12 Apr 2024

Name	Hearing Date
Helen Forde	25 Apr 2023
Katherine Robinson	27 Apr 2023
Vicki Graham	16 May 2023
Kate O'Neill	16 May 2023
Leanne McCourt	17 May 2023
Zoe Parks	18 May 2023
Sharon Glenny	18 May 2023
Fiona Reddick	23 May 2023
Marc Williams	23 May 2023
Tracey Boyce	24 May 2023
Aldrina Magwood	25 May 2023
Noleen Elliott	05 Jun 2023 06 Jun 2023
Gillian Rankin	07 Jun 2023
Patricia Kingsnorth	08 Jun 2023
Melanie McClements	13 Jun 2023
Deborah Burns	27 Jun 2023 28 Jun 2023
Trudy Reid	12 Sep 2023 13 Sep 2023
David Cardwell	13 Sep 2023

Name	Hearing Date
Patricia Thompson	14 Sep 2023
Darren Mitchell	19 Sep 2023
Chris Hagan	19 Sep 2023
Joseph O'Sullivan	20 Sep 2023
Anthony Glackin	20 Sep 2023 21 Sep 2023 19 Oct 2023
Mehmood Akhtar	10 Oct 2023
John P O'Donoghue	11 Oct 2023 07 Dec 2023
Ram Suresh	18 Oct 2023
Matthew Tyson	07 Nov 2023
Michael Young	08 Nov 2023 05 Dec 2023 06 Dec 2023
Robin Brown	14 Nov 2023
John Simpson	15 Nov 2023
Roger Kirby	15 Nov 2023 16 Nov 2023
David Connolly	04 Dec 2023
Eileen Mullan	09 Jan 2024 10 Jan 2024
Pauline Leeson	10 Jan 2024 11 Jan 2024

Name	Hearing Date
Richard Pengelly	16 Jan 2024
Roberta Brownlee	17 Jan 2024 18 Jan 2024 07 Feb 2024
Aidan Dawson	06 Feb 2024
Paul Cavanagh	08 Feb 2024
Sharon Gallagher	08 Feb 2024
Briege Donaghy	20 Feb 2024
Meadhbha Monaghan	21 Feb 2024