Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 102 of 2022
Date of Notice: 26 September 2022

Note: An addendum to this statement was received by the Inquiry on 11 May 2023 and can be found at WIT-94910 to WIT-94925

Witness Statement of: Zoe Parks

I, Zoe Parks, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

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

1.1 I have taken account of the inquiry Terms of Reference and included a narrative account of my knowledge of all matters falling within the scope of those terms, since I joined the Trust in my Medical HR Role.

1.2 Back in April 2004, a new consultant contract was introduced in N Ireland. Those consultants interested in transferring had to complete a diary card for the first time to help determine number of working hours, to inform transfer over onto the new time based consultant contract. On re-reading Mr O'Brien's diary cards today, I can see that he referenced in these manual paper forms the following comments: *"service which has been in crisis for years; gross overburden of clinical work*" This paperwork would have been submitted to the Clinical Director at the time and then onward processing via Dr C Humphrey, the Medical Director office, for a job plan offer. I was a medical staffing officer at this time, helping to provide HR support to the Medical Directors office in the implementation of the new consultant contract.

1.3 In September 2005 all new consultant offers were being prepared by the then Medical Director, Dr C Humphrey. Mr O'Brien was offered 14

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44.1 From working in Medical HR for quite some time, I am aware that MHPS Framework was to have been reviewed/updated by the Department of Health in the past (referenced in 2011 and 2018) but this has not happened to date. We continue to work with the original framework that was first issued to Trusts. There is a slightly different version in operation within the UK. The document is complex and given it is a different approach to how concerns are handled for other professional groups, I feel this has the potential to mislead those who have less experience using it, leading to a lack in confidence around handling concerns efficiently and compliantly in line with MHPS. *Please see:*

94. 00.11.2011 Revision to MHPS Changes DOH

95. 15.3.18 Response to DOH re mHPS review

96. 15.3.2018 SHSCT comments re revision MHPS to DOH

97. 15.4.2018 Review of MHPS response to DOH

98. 15.11.2011 Email re MHPS review with DOH

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

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 17 November 2022

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UROLOGY SERVICES INQUIRY

USI Ref: Notice 102 of 2022

Date of Notice: 9th May 2022

Addendum Witness Statement of: Zoe Parks

I, Zoe Parks, wish to add an addition to my response to S21 Notice Number 102 of 2022 to explain the development of Trust Guidelines for re-engaging retired consultants.

1.During 2018-2019, there were increasing numbers of consultants indicating they were considering early retirement. At this time, we were also starting to receive more queries from consultants around possibilities for retire and return options, which would not have been commonplace in the past. I believe this changing trend was influenced by government rules around pension taxation at that time. It was always our position that returning to work after retirement was not an entitlement and generally only considered in exceptional circumstances (such as hard to fill areas) and only then, if agreed, with the Associate Medical Director and Director of Service.

2. I recall a telephone conversation with the Head of Employer Relations from the British Medical Association, Mrs Christina Neely sometime in 2019. She mentioned that they had recently agreed guidance via the local negotiating committee in the Western Trust around re-engaging retiring consultants and asked if I would be willing to consider this – as it would be advantageous to have a consistent approach across Trusts. I agreed that this would be very helpful. The Assistant Director of HR within the Western Trust provided me with a copy of their guidance, which they had agreed on 14 November 2019.

3. I emailed Mrs Vivienne Toal, Director of HR, Mrs Siobhan Hynds, Deputy Director and copied to Mr Malcolm Clegg on 3 January 2020 stating the following: *"I would be*

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Statement of Truth

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

Signed: _____ Personal Information redacted by the USI _____

Date: _11/05/2023_____

been tackled and addressed as they arose. This should have been a proactive process undertaken by the operational and clinical managers collectively, taking advice as necessary.

40.3 I do believe we failed to fully and robustly utilise the contractual tools of job planning at our disposal to ensure Mr O'Brien discussed and agreed a contractual annual job plan – even if this meant pursuing facilitation and appeal mechanisms. This may have helped inform a more cohesive model of management as a repeated failure to comply with such obligations (and perhaps others like appraisal) may have stone the light to indicate potentially a broader problem in other areas of the doctor's practice.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

41.1 In my Medical HR role, I have a very limited standpoint to address this question – as I was on maternity leave when these concerns came to the attention of HR. However purely from rereading all the information that is available to me, I believe there may have been a failure to engage fully with the problems that arose within Urology Services to ensure they were fully and properly scoped out.

41.2 All consultants practice independently and are clinically responsible for their own patients. I believe this peculiar aspect to their role can mean there may be less emphasis in this profession and at this grade, on the typical methods for line management such as regular 1:1 supervision meetings. Whilst Clinical Directors and Associate Medical Directors are responsible and accountable for the medical staff within the Speciality and their role in the provision of services – I believe extensive consideration is needed right across the NHS (as opposed to being unique to the Southern Trust) on how best this model can work, so that they are fully supported, trained and motivated to carry out this important management role alongside their clinical practice.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

Southern Health and Social Care Trust

Local Trust Framework on Job Planning for Medical Managers

Southern Health and Social Care Trust

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

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

Please also refer also to:

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

A Guide to Job Planning

for Consultant Urologists

2016

www.baus.org.uk

British Association of Urological Surgeons

Southern Health and Social Care Trust
Quality Care - for you, with you

Local Trust Framework for Job Planning

Final

Author Zoe Parks: Head of Medical Staffing

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

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 04 October 2019 16:53
To: OKane, Maria
Subject: FW: Action notes from meeting 24-4-19
Attachments: RE: Urology (176 KB); FW: Urology (11.2 KB)

From: Haynes, Mark
Sent: 31 May 2019 09:08
To: OKane, Maria; Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth
Subject: RE: Action notes from meeting 24-4-19

Morning

RE Job Plan;
Mr O'Brien does not have a signed off job plan. Discussion have occurred and the job plan has been 'awaiting doctor agreement' since November 2018. I am second sign off and so would not be requested to sign it off until he and his CD have signed it. I have requested an update on the process from the relevant CD.

RE 2017 action plan;
I am currently not in a position to provide the reassurances requested. I was not party to the action plan at it's inception and have only recently been made aware of it's contents. Having been made aware of it's contents, I am aware of instances where the actions regarding Concern 1 have not been met (see attached emails), specifically;

'…triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily.'

Given that I am aware of aspects of the action plan not being met, I am concerned to see the statement that there have been 'no exception reports flagged to case manager'. The implication being that either there has been an agreed deviation from the action plan and monitoring is now occurring against different standards, or that the monitoring and / or escalation process has not functioned as it should.
As I was not party to any of the previous discussions, if I am to become part of this I need an initial briefing with all and also some run through of monitoring to date. Through this briefing I need to understand the process as it is at present, and how, despite evidence that there appear to have been 'exceptions', the reporting process appears to have failed to flag these to the case manager.

Mark

From: OKane, Maria
Sent: 30 May 2019 18:06
To: Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth; Haynes, Mark
Subject: RE: Action notes from meeting 24-4-19

Thanks Simon.
- Ahmed or Mark as his AMD should seek regular assurance rather than me and then inform the MDO
- AOB is still undertaking assessments at private clinic at home as per the requests to sign off on transfers from private to public practice. I brought this to the attention of urology. We have asked for a rationale as to why the GMC has suggested this practice is stopped before this is progressed – please explore with them Simon.

Review of Diary Cards

Following the discussion with Mr O'Brien at facilitation, it was possible for Dr Gaston to review the diary cards and refine the information recorded. A summary of his calculations has been included:

Direct Patient Care:		
Week	**Activity**	**PA's**
Week 1	Direct Clinical Care	9.50
Week 2	Direct Clinical Care	9.88
Week 3	Direct Clinical Care	11.25
Week 4	Direct Clinical Care	11.13
Total PA's		41.75
Average / Week		**10.44**

Supporting Professional Activities:		
Week	**Activity**	**PA's**
Week 1	SPA	0.13
Week 2	SPA	0.00
Week 3	SPA	0.00
Week 4	SPA	0.00
Total PA's		0.13
Average / Week		**0.03**

On-call Allocation:	**2.00**

Premium Time Workload:		
Week	**Activity**	**PA's**
Week 1	Premium Time	0.67
Week 2		1.00
Week 3		1.67
Week 4		2.67
Total PA's		6.00
Average / Week		**1.50**

TOTAL PA'S	**13.97**

CONSIDERABLE During the review of the diary cards, it became apparent that Mr O'Brien spent a ~~consideration~~ amount of time on Patient Administration. This was significantly above the average for his colleague and the other General Surgeons. Although no adjustment was made, it was felt that this should be addressed in the future.

Supporting Professional Activities

Dr Gaston reviewed the information provided by Mr O'Brien on supporting professional activity and external duties. It was felt that although this activity was not addressed in the diary, it would have been undertaken during the

documents are also available via the Trust Intranet site under Directorates, HR & Organisational Development, HR Medical & Dental."

1.11 On 2 June 2011, I was asked by the Chief Executive Mrs M McAlinden to issue a High level summary of progress with Consultant Job Planning by email to improve communication and transparency across the Trust to all Consultants and Staff Grade Doctors. *Please see:*

18. 00.06.2011 Update on Consultant Job Planning for all Consultants
19. 2.6.11 High level summary of Job planning to consultants
20. 2.6.2011 Email issuing high level summary

1.12 In July 2011, I assisted with a Disciplinary investigation concerning Mr A O'Brien relating to the disposal of clinical notes in a ward bin. I was asked to provide HR Support to Mr Robin Brown (a consultant surgeon from Daisy Hill Hospital site) who had been appointed at the Case Investigator. A full investigation report was completed and shared with the doctor and his managers. To our knowledge this was an isolated incident and resulted in an informal warning being issued to Mr A O'Brien. A full copy of the disciplinary report and outcome letter has been attached in my summary evidence table. *Please see:*

21. 01.06.2011 FINAL Disciplinary Report - A O'BRIEN
22. 9.8.2011 Informal warning outcome Mr A O'Brien

1.13 On 28 September 2011, Mr A O'Brien had a Job Plan Facilitation Meeting with Associate Medical Director, Dr P Murphy. This meeting was supported by my HR colleague Mr Malcolm Clegg. I was not in attendance. I am aware from paperwork that I have read in preparing for this public inquiry that the offer was 12.75 PA's WEF 1 October 11, to revert to 12PA with effect from 1 March 2012. The offer of the additional 0.75 for a period of time was for administration. Mr O'Brien responded at the time via email to my colleague Mr M Clegg at the time to say "…*By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate."*

Clegg, Malcolm

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

Malcolm,

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

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

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

Aidan O'Brien

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

Mr O'Brien,

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

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

I trust this helps to clarify your queries.

Regards

Subject: Post Facilitation
From: Mackle, Eamon <Personal Information redacted by USI>
To: O'Brien, Aidan <Personal Information redacted by USI>, McCorry, Monica <Personal Information redacted by USI>
Cc: Trouton, Heather <Personal Information redacted by USI>, Rankin, Gillian <Personal Information redacted by USI>, Corrigan, Martina <Personal Information redacted by USI>, Clegg +1 More
Sent: 12/5/2011, 4:46:43 PM
Dear Aidan

As you are aware in the letter post your job plan facilitation it was stated: “This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.”

I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven’t met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without need for Trust support then you obviously do not need to contact me to organise a meeting.

Kind Regards

Yours Sincerely

Eamon Mackle

27. E re Job Plan Facilitation A2 - 31.10.2011

1.17 On 9 December 2011, I issued a memo via email to Associate Medical Directors and Clinical Directors regarding the process for Waiting List Initiatives and some issues that had been flagged to me across the Trust by payroll for this extra contractual work. This was a reminder email for all Clinical Managers about the process and how claims should be completed and approved.

1.18 On 6 January 2012, I emailed Mr Colin Weir a copy of the NCAS Handling Concerns good practice guidance. To the best of my recollection, this was in the context of planning for a training workshop for consultants on handling concerns (particularly junior doctors), in his role as Director of Medical Education and Training. On Mr Weir's request, I later delivered a local training workshop on handling concerns about doctors on 2 October 2013. This was provided on a further occasion on 22 September 2015**.** I don't have an attendance list of who attended as this would have been held by the Medical Education Office. *Please see:*

28. 2.10.13 Case Studies for Managing Concern Workshop
29. 2.10.13 Handling Concerns Medical Staffing Presentation - Z PARKS
30. 2.10.2013 Copy of concerns presentation to Mr C Weir
31. 6.1.12 NCAS -Handling Concerns good practice
32. 6.1.2012 Email to C Weir with Concern Guidance
33. 22.9.15 Managing Concerns Presentation

1.19 On 30 January 2012, The Director of Acute Services, Dr G Rankin forwarded me a letter she had received by email from Mr O'Brien regarding a complaint he had around incorrect payment for waiting list initiative (extra contractual work) he had undertaken during July 2010-Feb 2011. I was asked to look into the complaint. I could see from the claim form that the amounts claimed by Mr O'Brien were completed on Fridays and some weekends. There were no times recorded. A WLI session is paid differently to contractual programmed activities, WLI are enhanced rates of £[redacted] per 4 hour session or £[redacted] per 4 hour session at weekends. 21 sessions were being claimed (15 on Fridays and 6 on Saturdays; total amounting to £[redacted]) When the claim form had gone to Mr Mackle and Mrs H Trouton for approval it appeared that the amounts being claimed had been halved (in pen on the form) before approval. These forms do not get submitted via Medical HR (they go via Medical Directors office) so on receipt of Mr O'Brien's complaint, I had

Personal Information redacted by USI

30 January 2012.

Dr. Gillian Rankin,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Rankin,

I wish to take this opportunity to formally submit, in writing, a grievance regarding the deductions made to the payments owed to me on foot of a claim for extra contractual work. These deductions amount to a breach of agreement with management regarding the rate of remuneration for the sessions claimed, a rate subsequently reaffirmed to me by management.

In the autumn of 2010, it was agreed by the Head of ENT and Urology that I would be remunerated one additional sessional payment for conducting combined urodynamic studies and oncology reviews all day Fridays in the Thorndale Unit. I enclose a copy of the claim form submitted 2nd March 2011, consisting of a claim for 15 such sessions in addition to 4 sessions of Inpatient Operating and 2 sessions of Urodynamic Studies completed on Saturdays.

When I received payment of £Personal Information redacted by USIgross in April 2011, I was unable to recognise the amount. In contacting the Payroll Department, I was advised that payments for additional Friday sessions had been halved, whilst the remaining sessions had not been paid at all. When I enquired why deductions had been made, the Payroll personnel informed me that they were unable to decipher the signature of the person who had made the deductions. For that reason, I was provided with a copy of the claim form (enclosed). It was evident to me that the deductions were made by Mr. Eamon Mackle. I subsequently received payment for the unpaid Saturday sessions in May 2011.

To date, I have not received full payment in respect of these sessions, nor have I received any communication regarding same, apart from verbal confirmation of the agreement.

Agreed it is appropriate

Misunderstanding should not have happened

Parks, Zoe

From: Parks, Zoe [redacted]
Sent: 24 February 2012 14:51
To: Gannon, Oonagh; Porter, Pamela
Subject: Waiting List Initiative Claims - Mr A O'Brien
Attachments: SKMBT_C22012022415080.pdf

24 February 2012

Mr A O'Brien,

Re: Waiting List Initiative Claims

You will see from the attached correspondence that Mr A O'Brien recently wrote to Dr Rankin about some changes that had been made to WLI claims that he had submitted for work undertaken between July 2010 to February 2011. These claims were changed by the AMD Mr E Mackle but I have spoken to Mr Mackle and Heather Trouton and it seems there was some misunderstanding about what had been agreed against his job plan. However they have agreed to concede as changes shouldn't have taken place without prior discussion with Mr O'Brien.

Therefore I wish to confirm that it has been agreed that Mr O'Brien should have been paid what was originally included on the WLI forms. I would therefore be grateful if you could arrange to reimburse Mr O'Brien £[redacted] x 15 occasions – as shown on the attached forms.

If you have any queries please do not hesitate to contact me.

Many thanks

Mrs Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: [redacted]
Blackberry: [redacted]
Fax: [redacted]
Email: [redacted]

From: [redacted]
Sent: 24 February 2012 15:09
To: Parks, Zoe
Subject: Message from KMBT_C220

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

MICHAEL O'BRIEN: That's exactly.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: There is also another issue with regard to this meeting and that is that, whilst we don't want to personalise the issue, Mr Mackle~~cIll~~ should not have been involved at all because my father had had a formal grievance against Mr Mackle~~cIll~~. Now that grievance was stayed effectively.

MR O'BRIEN: I suspended it because [redacted] and with the -- on condition that I could initiate it again at any time in the future, which I haven't done. And, you know, one can only speculate as to whether this letter would have been followed up with some kind of informal attempt to resolve the issues had it been someone other than Eamon Mackle~~cIll~~, but, in a sense, that's secondary to the fact that there was no informal process.

JOHN WILKINSON: Okay. But so you're -- I've got the first scenario. The second scenario is that there was a case sitting with regards -- as it were, suspended by you against Mr Mackle~~cIll~~ and he was -- is he your direct line manager?

MR O'BRIEN: Not my first line manager. The lead clinician is Mr Young.

JOHN WILKINSON: Sorry, I do know him. That's a problem for you?

MR O'BRIEN: No, it's not at all. No.

JOHN WILKINSON: [redacted] So as long as there is no problem for you.

MR O'BRIEN: No. None whatsoever.

JOHN WILKINSON: Okay. Right. So there was -- if we look at it then, he was a couple of --

MR O'BRIEN: People about that, yes, associate medical director, yes.

JOHN WILKINSON: All right.

MR O'BRIEN: At that time. He's no longer.

JOHN WILKINSON: Right. Okay

MICHAEL O'BRIEN: But it had also been agreed at that time of the -- around that time the grievances were being issued that he would have no dealings with him again.

MR O'BRIEN: Yes. I sought and obtained an assurance from Dr Rankin and from Eamon Mackle~~cIll~~ himself, particularly from Dr Rankin, that I would have no more dealings or meetings with him because I was on the point of breakdown as a consequence of his treatment over a period of years. But anyhow, as I said to you --

JOHN WILKINSON: Was this agreement before this letter was issued?

MR O'BRIEN: Absolutely. Years before, yes.

MICHAEL O'BRIEN: And it had never been broken before.

MR O'BRIEN: No.

JOHN WILKINSON: Fine. That's okay.

MICHAEL O'BRIEN: That would be -- it would seem inappropriate that he would be involved at all.

JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: That point is in the first page. So there are a number of questions that arose out of it. Was MHPS actually involved in the decision to issue this letter? I am not sure on that at all.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: If a decision was taken under MHPS it would have had to have involved the medical director, wouldn't it? (Inaudible). Because it would go to an oversight committee in the same way.

JOHN WILKINSON: MICHAEL O'BRIEN But you had a meeting with the medical director about a week --

MR O'BRIEN: Yes, just one week later, on 1 April 2016, on entirely unrelated issues. Two issues one was trying to improve the radiological input into our urologyical MDM. So that's completely unrelated to any of this. And the other one was that he was advising me to try to reduce my workload, which is an irony. My own view of this matter, and I am speculating, I don't believe that Dr Wright knew of the letter of 23 March at that time. And I suspect, it is just a suspicion, that he has been misadvised perhaps or misinformed as to there being an informal process when there definitely was no informal process.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: You see the reason why that's interesting is because under the guidelines -- I'll find it in a second. At page 8 I think it is. Paragraph 15 does say that:

"If an informal approach can address the problem whether a formal investigation is needed. This is a difficult decision. It should not be taken alone but in consultation with the medical director and the director of HR, taking advice from NCAS where necessary."

So it seemed that if it this was under MHPS it would probably have involved the medical director, so we doubt that it was at all.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: But that's the March 23 letter. We don't really how that fit into it all. We would look like to know the answer to that.

(c) Advising on the necessary communications with a Locum Agency and Responsible Officer regarding an issue with a Urology locum consultant Dr [Personal Information redacted by the USI] in 2020. Details included in question 17.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern, on the provision, management and governance of urology services?**

28.1 In relation to the conduct concern that was investigated regarding the disposal of clinical notes by Mr O'Brien in 2011, the Case Manager's understanding was that this was an isolated incident. The full report was shared with the Associate Medical Director Mr Mackle and the Assistant Director Mrs H Trouton. Mr O'Brien apologised and agreed that disposal of the material concerned was inappropriate and that it would not happen again. He was issued with an informal warning under the Trust's Disciplinary procedure and I am not aware this practice was ever repeated and therefore the action taken seemed to address this issue. However I am concerned to read in the context of this public inquiry that there were ongoing issues with the management of patient charts with Mr O'Brien storing a large volume of these at home. I believe given the previous context, this should have been immediately escalated and dealt with in line with Trust policies and procedures.

28.2 In relation to the clinical concern in 2012 relating to the temporary LAT (Locum Appointment for Training) doctor, when concerns came to light, an initial screening was completed. This resulted in immediate restrictions being put into place. These included coming off the on-call rota, restricted practice with supervision and a period of time accompanied by the Urology SPR (Specialist Registrar) for Urology ward rounds. An investigation was undertaken in line with the Terms of Reference with full participation from the doctor and a number of witnesses. As this doctor was only on a temporary contract which ended during this period, the Case Manager (CM) followed Section VI para 7-9 of MHPS to take the investigation to its final conclusion wherever possible. Mr E Mackle as CM, concluded that on the balance of probabilities there was at least some evidence to substantiate some of the concerns in relation to the doctor's clinical performance. Had he remained in Trust employment, he would have recommended further formal consideration by NCAS and a likely action plan to address these deficiencies. However since he was no longer employed, the Trust could take no further action in this regard, but to

38.2 I am aware from reading the material in preparation for this public inquiry that a letter was issued to Mr O'Brien in March 2016 by his Clinical Management team raising concerns, particularly around administrative practice and current review backlog. I understand HR were not informed of these concerns at that time. I was off on Personal Information redacted by USI leave but I believe it would have been helpful to have sought specialist HR advice at that time.

38.3 I believe this initial concern should have prompted immediate preliminary enquiries by the clinical manager to take a deeper dive and scope to establish the full nature of the concern. The fundamental consideration within the MHPS Framework is the continued safety of patients and the public. Action when a concern first arises requires the clinical manager to consider if urgent action needs to be taken to protect the patients and if a precautionary restriction/exclusion on practice is required, until they can clarify the nature of the concern. The key Governance question I am asking is that no one seemed to understand or take accountability for determining the full extent of the problem, to ensure any necessary protective measures for patients could be put in place immediately and properly monitored.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 On very first receipt of the prompt/concern, the response should have been for the clinical manager to very quickly ascertain what had happened. They needed to establish the facts, determine if there was a continuing risk and decide if there was action needed to manage any risk to ensure the ongoing protection of patients. It is not clear to me what action was taken following the meeting in March 2016. I note the request was to ask Mr O'Brien for an immediate plan to address the issues highlighted. I don't believe this was appropriate, given these were significant concerns which I believe met the threshold for formal investigation at that time. It may also have warranted an immediate interim review of Mr O'Brien's Job plan to ensure the necessary corrective reviews being asked of Mr O'Brien were possible.

39.2 More rigorous and robust action at this early stage may well have been a missed opportunity to ensure preliminary enquiries triangulated and documented all available data at that time. Had a robust review been undertaken, this may have allowed an earlier link between

administrative practices and impact on patient care, so protective measures could have been immediately implemented and monitored. From my experience over the years advising on cases, the role within MHPS for monitoring and managing risk (which is not well defined in the Framework) needs to lie with the immediate line manager to avoid any possible disconnect. They must remain accountable for ongoing line management and must update the case manager (in the context of formal MHPS investigations) on the actions they have taken. NHS Resolution can be very helpful in helping to draw up detailed action plans as necessary, I have attached a sample one into evidence that we have used previously as an example.

39.3 An assessment of an initial incident for its risk, so that the correct measures can be put in place to protect patients, has to take precedence over everything else. In my view this is the most critical aspect within MHPS. For example, by correctly identifying that a risk associated with a trigger event is low, sufficient reassurance can be gained that the issue is not a concern and can be dealt with as a learning incident. However as preliminary enquiries are undertaken and further events occur or information comes to light, the risk may vary, so a trigger initially classed as a low risk incident may rise to medium or high if other instances come to light or you have a doctor with little insight. Clinical Managers (taking advice when necessary) must continue to reassess risk as often as is necessary as part of their line management role. Case managers (as assigned under MHPS) should then seek the assurance they need from clinical line managers that all necessary protective measures are in place. We need to ensure managers are trained and supported to undertake this task.

39.4 I understand a screening report was completed in September but it is not clear why this was done by the Assistant Director in the Medical Directors office – this should have been the clinical manager who should have been responsible for retaining ongoing oversight. Input from NCAS (now NHS Resolution) could have provided additional support if this was needed to assist with the review of notes.

39.5 It is not clear to me why it took an SAI investigation in December 2016 to instigate formal action– I'm not clear if these were new concerns arising or if a closer review earlier would have uncovered them. Unfortunately it would seem the earlier inaction led to a delay to the formal investigation as there was still a need to determine the full extent

of the problem. I believe a more robust review at the outset may have avoided this.

39.6 I am aware that there were more difficulties encountered which prevented the completion of the MHPS process, however I was not in my post during 2015 and most of 2016 (Personal Information redacted by the USI) so I am not fully aware of all the factors that led to these delays. I do think that the key breakdown stems back to the fact an adequate and robust review, coupled with a risk assessment does not appear to have been completed and there were missed opportunities to address this as time went on. *Please see:*

93. Sample Action Plan NHS Resolution

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

40.1 The challenge for all managers is they are responsible for what is actually happening, regardless of what personal knowledge they hold at that time. Given what I know now; we need to ensure all managers are clear in their role and supported to undertake it fully and robustly. I do believe the governance systems need to be strengthened to triangulate data for clinical managers, so they are better aware how clinicians are performing in all aspects of their role. However there must also be a culture that where concerns arise (even if all information is not clear), the concern must be robustly evaluated to ensure the full extent of any concern is established and managed at the earliest possible opportunity. Clinical Managers must be clear in their role and supported to ensure this is the case.

40.2 The learning also has to be around fostering and encouraging a more open, transparent and fair culture for raising and managing all concerns, as soon as they arise. It is not appropriate to wait until one is sure there is a concern before escalating – that is the purpose of an investigation to uncover. Early escalation allows the necessary precautionary risk assessment to be undertaken immediately to prevent any possible harm to patients, clients or staff. When *possible* concerns are not escalated or enquiries not undertaken, this has the potential to undermine patient safety. Any perceived concerns should have resulted in decisive action and untoward behaviours should have

Urology Services Inquiry

42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1 The immediate response under MHPS Framework is to manage risk to ensure patient safety is protected. I believe this should have been the key priority right at the outset. There needed to be greater triangulation of clinical data/performance indicators to provide assurance the Trust was fully aware of the nature of the concern at that time. However in the absence of that, the necessary risk assessment needed to be completed right at the outset to protect any ongoing risk of harm.

42.2 Clear, transparent and documented communication with the individual practitioner is also essential. Informal management within the specialty does not mean undocumented and therefore as soon as concerns were discussed in March, this should have been accompanied by a documented action plan with clear lines of responsibility, set and monitored by the local clinical management team.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 I would have a limited standpoint to answer this question as I would not be familiar with the specific governance systems or clinical performance indicators in place within Urology that should pick up if things start to go wrong.

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

There are two gateways in each of the eight paybands:

1 the foundation gateway – this takes place no later than twelve months after an individual is appointed to a payband regardless of the pay point to which the individual is appointed.

2 the second gateway – this is set at a fixed point towards the top of a payband as set out in the National Agreement (see below).

Pay band	**Position of second gateway**
Pay band 1	Before final point
Pay bands 2 – 4	Before first of last two points
Pay bands 5 – 7	Before first of last three points
Pay band 8, ranges A – D	Before final point
Pay band 9	Before final point

Review of individuals at the gateways is based on using the dimensions and levels of the NHS KSF that are relevant to that post.

The purpose of the foundation gateway is to check that individuals can meet the basic demands of their post on that payband – the foundation gateway review is based on a subset of the full NHS KSF outline for a post. Its focus is the knowledge and skills that need to be applied from the outset in a post coupled with the provision of planned development in the foundation period of up to 12 months.

The purpose of the second gateway is to confirm that individuals are applying their knowledge and skills to consistently meet the full demands of their post – as set out in the full NHS KSF outline for that post. Having gone through the second gateway, individuals will progress to the top of the pay band provided they continue to apply the knowledge and skills required to meet the NHS KSF outline for that post.

There is an expectation that individuals will progress through the paypoints on a payband by applying the necessary knowledge and skills to the demands of the post. It is only at gateways, or if concerns have been raised about significant weaknesses in undertaking the current role, that the outcome of a review might lead to deferment of pay progression[4].

The whole system is based on the principle of NO SURPRISES – if there are problems with individuals developing towards the full NHS KSF outline for the post, or there are disciplinary issues, these must have been addressed by reviewers **before** the gateway reviews. This mirrors good management practice and should be no different from good appraisal practice as it currently exists.

There must always have been formal notification of any concern to the individual by their reviewer. An action plan must have been drawn up to try to remedy any issues before deferral of progression can be raised. The process after that will be exactly the same as in deferral at a gateway with progression resuming as soon as a review determines that the NHS KSF outline for the post and the gateway has been met. Deferral will last until any issues are resolved.

4 'Significant weaknesses' have been defined in the negotiations as "significant weaknesses in performance in the current post that have been identified and discussed with the staff member concerned and have not been resolved despite opportunities for appropriate training/development and support".

Southern Health and Social Care Trust

Quality Care - for you, with you

Training Plan

Maintaining High Professional Standards (MHPS)

Lead Author & Job Title:	Zoe Parks, Head of Medical HR
Directorate responsible for document:	HROD
Issue Date:	01 September 2022
Review Date:	01 September 2024

2018

Southern Health and Social Care Trust

Quality Care - for you, with you

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

October 2017

(c) The Assistant Director changed from Mrs H Trouton to Mr R Carroll in April 2016.
(d) The HR Director transferred from Mr Kieran Donaghy following his retirement to Mrs Vivienne Toal in 2016.

26.2 Such key changes over a short space of time is bound to have been difficult, as staff structures and interactions are crucial in an organisational system. I believe this may have had the potential for organisational memory to be impaired, particularly if any issues were being handled via informal ways of working. I also note that in May 2016 the Associate Medical Director Dr McAllister was asked to cover Surgery/Elective Care Directorate as AMD at the same time as his own area ATICS (Anaesthetics/Theatres/Intensive care), which can't have been easy, given he is also a full time clinician. There is a huge challenge in medical management posts, as often in my experience they cannot give up their clinical workload due to sheer workforce pressures (and not enough doctors to backfill them) and often don't want to, due to the deskilling that can occur if out of clinical practice for a period of time.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 As outlined in question 17, I have provided HR support to manage a number of concerns that were raised in the past regarding Urology practitioners. These included the following:

(a) Providing administrative support and HR guidance to a Surgery Clinical Director, Mr R Brown in a disciplinary investigation concerning Mr A O'Brien in 2011 relating to the disposal of clinical notes in a bin on the ward. This resulted in an informal warning. The full details and decision letter were shared with Mr O'Brien, Mr Mackle the Associate Medical Director, and Heather Trouton, Assistant Director at the conclusion. Further details included in question 17.

(b) Providing administrative support and HR guidance to Clinical Director Mr R Brown in completing an investigation concerning clinical concerns relating to a temporary LAT [redacted] (Locum Appointment for Training) in Urology in 2012. Further details included in question 17.

to the responsibility of the relevant Head of Service/Director for that area, so I would not normally have sight of this.

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 Ensuring we have an adequately resourced Medical HR unit to support more frequent and widespread training on handling concerns would increase effectiveness in carrying out my role. I have developed a Training Plan as referenced and evidenced at Q13. Medical HR is a specialist area and I do believe additional resources will help us raise awareness and facilitate pro-active training amongst clinical and operational managers on how to handle concerns. We need to continually strive towards a climate that emphasises organisational learning and explore how we can underpin our processes, systems, polices and regulatory frameworks with restorative principles and practices.

35.2 I have recently been given approval to recruit at risk for a new band 7 specialist MHPS case manager. This will be a dedicated MHPS role, something that we have not had in the past. In the past our support has always been in addition to an operational role carrying busy day to day responsibilities. This additional resource will also allow us to support the necessary continuous improvements in this field of work.

35.3 Developing Clinical Leadership induction training is essential. The challenge of being a clinical leader cannot be underestimated. Particularly, as most often these appointments are internal and one can end up managing colleagues who were once their senior or, at the least close contemporaries. Administrative support for clinical managers for their management role is also something that I believe should be considered as I know many rely heavily on Medical HR support which is finite due to our resources.

35.4 Ensuring enough time is allocated within Job Plans to facilitate clinical management is an ongoing challenge for Trusts when clinical commitments are ever increasing – however this is critical. It is not easy or straight forward for many reasons, not least the huge funding and staffing shortages faced by Trusts.

35.5 Continuing to build skills and competencies is important to promote a proactive coaching culture where all managers and staff know they have a clear responsibility to ensure and assure themselves of patient safety. I am not aware if there were adequate systems in place to allow for

regular peer review of clinicians work as part of supervision/management. Managers must continue to feel empowered to deal with any possible risk to patent safety at the earliest possible opportunity – with appropriate oversight to ensure action where necessary. Staff need to feel empowered and supported to raise concerns prior to any potential risk of patient harm, ensuring there are well communicated processes to address such concerns and systems in place to learn from good practice as well as what goes wrong.

35.6 Reviewing MHPS Framework to ensure processes do not serve to stifle or complicate pathways for correction. Most importantly ensuring patient safety remains at the core is critical – so greater clarity on the action to be taken when a concern first arises would help. The MHPS Framework does not give clear practical steps for clinical managers to follow for addressing concerns at the outset, ensuring matters are properly risk assessed, managed and documented very early before they reach a stage when more formal action is necessary.

35.7 There are other factors within the MHPS Framework that need greater clarity such as clear definitions of all the roles referred to in the document. The importance of having roles defined and clear lines of accountability around every aspect of the process cannot be overstated. The timeframes are also in need of review as they are not realistic within an over stretched busy NHS – albeit I appreciate they have to be reasonable. The MHPS Framework is silent in many areas such as whether a case manager can take soundings before reaching their decision and yet this would seem a sensible approach and in line with Baroness Harding advice. What constitutes a 'concern' is not well defined and yet it asks that "all" concerns are registered with the Chief Executive. Professional misconduct is not defined. At the end of an investigation, a Case Manager has to consider if there are 'intractable' problems and yet again, this term is not defined. In cases of misconduct, the document is also contradictory as it indicates in the introduction you can follow your own local disciplinary procedures and yet it has a Section 3 which states you can only apply conduct procedures when an investigation under section 1 shows there is a case of misconduct. Paragraph 39 talks about confidentiality but it is not clear how far this extends. Whilst I appreciate a complete rewrite may not be feasible given Case law has dealt with many issues – the sheer volume and complexity of the document in its current format is not helpful. General principles for Formal investigations are also right at the back of a 40+ page document when it would seem more sensible for a set of clear principles to be at the beginning of a

*grateful to discuss the attached **draft** **document** when you get a chance. We have an increasing number of retiring consultants some of whom enquire if they can return and/or their service manager is keen to retain them post retirement. We always had a very draft document ensuring there was some process around this but it was never formalised. Western Trust recently got LNC agreement and this Draft reflects their document. Christina Neely shared it with me to see if we could agree on something similar."*

4. On 27th January 2020 at 08.09am, Mrs Vivienne Toal responded by email saying:

"*Zoe – apologies for taking so long to read this and comment on it. Interestingly we have been talking about this for other grades of staff and the need to document something. I hadn't seen your email when we were talking about this a couple of weeks ago at senior leadership meeting. (sharing with ADs for information – while the general one could look something like this it is probably best to keep them separate documents, as the solution for non-medical staff may be slightly different, and it will probably hold yours up Zoe if we wait to do one document) I have added two comments on this for your consideration. Happy for you to proceed to link with Christina Neely. DDs and ADs – if you wish to comment can you forward anything through to Zoe please? Thanks Vivienne"*

5. Mr O'Brien contacted Mr Malcolm Clegg by phone and email on 13 February 2020 to indicate that he was considering retirement. He requested the relevant application forms for his retirement. I understand from speaking to Mr Clegg recently, that during the conversation there was a brief discussion on whether he could return to work, post retirement. Mr Clegg advised that this would not be automatic and have to be discussed and approved by the Associate Medical Director. HR had no further involvement in these discussions at that time.

6. I received a phone call from Mr M Haynes sometime early June 2020. He asked me to provide him with a form of words to allow him to respond to Mr O'Brien to advise that the Trust would not be willing to re-engage him following retirement. I advised him of our guidance and provided the following via email on 9 June 2020:

Southern Health and Social Care Trust

Quality Care - for you, with you

Re-engaging Retired Clinicians

Guidelines for re-engagement of Retiring Clinicians

Agreed with Southern Trust LNC (BMA) July 2020

Introduction

In order to continue to deliver services to patients there may be occasions when the Trust will need to continue to engage the services of a retiring clinician (primarily but not exclusively consultant and SAS) in a post-retirement position. This document sets out the arrangements for this to happen. There is no obligation on any clinician who is retiring to continue to provide services to the Trust, and equally clinicians do not have an automatic right to re-engagement. These guidelines do not apply to anyone who has already retired from the Trust.

Management activities on receipt of notice of retirement

The Service Director will assess the overall situation with regards to the clinical needs of the service area. This may involve seeking the advice of the Associate Medical Director and the Director of the Service area to establish if there is a need to consider re-engagement, and subsequently a senior HR manager with responsibility for Medical HR should this be required. The following alternatives to re-engagement should be considered as part of the decision making process:

- Doctors who may wish to act-up into the role until it can be permanently recruited for
- Trainees who are completing their training and are eligible to apply for the post
- Review of existing job plans of the remaining clinicians
- SAS doctors.
- Opportunity through International Recruitment Initiatives

Process of re-engagement

Having considered all of the alternatives, the Service Director may conclude that there is no alternative but to ask the clinician if s/he is willing to be re-engaged, following their retirement. This conversation must take place while the clinician remains in the employment of the Trust and arrangements put in place prior to their retirement date.

Before proceeding to re-engage a retired clinician the Service Director should, in conjunction with a Senior HR Manager responsible for Medical HR, consider the following:

- That there are no outstanding or unresolved concerns regarding the clinician's overall performance and conduct.

- The clinician is medically fit to perform the role having demonstrated an acceptable level of attendance (subject to Disability Discrimination Act requirements).

The assumption must always be that the Directorate will recruit a replacement as normal however in circumstances where it is clear the delivery of the service would be put in jeopardy by the loss of the individual, the Service Directors can, with the prior approval of the Medical Director, Director of Human Resources and Service Director, offer the individual Clinician a fixed term appointment (normally for up to 12 months). This

McNeice, Andrea

From: Parks, Zoe [Personal Information redacted by USI]
Sent: 13 April 2020 14:13
To: McNeice, Andrea; OHanlon, Niambh
Subject: FW: Notice of Retirement
Attachments: Letter of Retirement.docx

For info

From: Corrigan, Martina
Sent: 13 April 2020 14:09
To: Clegg, Malcolm; Parks, Zoe
Cc: Carroll, Ronan; Haynes, Mark; Young, Michael
Subject: FW: Notice of Retirement

Dear all

Please see attached. I can confirm that I have acknowledge receipt of this with Mr O'Brien.

Can you advise is there anything further that I need to do with this please?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT [Personal Information redacted by USI] (Internal)
[Personal Information redacted by USI] (External)
[Personal Information redacted by USI] (Mobile)

From: O'Brien, Aidan
Sent: 26 March 2020 23:17
To: Corrigan, Martina
Subject: Notice of Retirement

Martina,

Each day my intent to send you a 'Letter of Retirement' has fallen by the wayside.
I have managed to remember to do so this evening,
It is a surreal moment, after 28 years!

Aidan.

Davis, Anita

From: Carroll, Ronan
Sent: 17 December 2021 15:30
To: Davis, Anita
Subject: FW: Notice of Retirement

Follow Up Flag: Follow up
Flag Status: Completed

Section 21
Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI

From: Haynes, Mark Personal Information redacted by USI
Sent: 15 April 2020 10:31
To: Carroll, Ronan; Corrigan, Martina
Cc: Young, Michael
Subject: RE: Notice of Retirement

Needs more discussion than can be had at present.

In short yes, but with strings attached, and these strings need to be clear and accepted before he is offered anything.

Mark

From: Carroll, Ronan
Sent: 15 April 2020 10:29
To: Corrigan, Martina
Cc: Haynes, Mark; Young, Michael
Subject: RE: Notice of Retirement
Importance: High

We are taking Aidan back – yes?

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mobile Personal Information redacted by USI

From: Clegg, Malcolm
Sent: 15 April 2020 09:32
To: Corrigan, Martina
Cc: Carroll, Ronan; Haynes, Mark; Young, Michael
Subject: RE: Notice of Retirement

Hi Martina,

Mr O'Brien's application for pension benefits is all in hand. He will be processed as a leaver on HRPTS from 30th June 2020.

You will just need to let us know if it has been agreed for him to return to work following 'retirement' and if so, from what date, as we will need to reinstate him to the Payroll.

Thanks

Malcolm

Malcolm Clegg
Medical Staffing Manager
Medical Staffing Department
The Brackens
CRAIGAVON AREA HOSPITAL
BT63 5QQ

Tel No: Personal Information redacted by USI or ext Personal Information redacted by the
Mobile: Personal Information redacted by USI

From: Corrigan, Martina
Sent: 13 April 2020 14:09
To: Clegg, Malcolm; Parks, Zoe

Parks, Zoe

From: Parks, Zoe [redacted]
Sent: 09 June 2020 17:24
To: Haynes, Mark
Subject: In confidence

As discussed yestersay, I can confirm that when you resign/retire from the Trust, your contract of employment ends at that time. We discussed your request to be reengaged and confirmed that in line our normal practice, your request has been considered. I have discussed this with the Director of Acute Services and we have decided that we are not in a position to reenage given the outstanding MHPS/GMC processes that have still to be concluded.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 98 of 2022

Date of Notice: 26 September 2022

Note: An addendum amending this statement was received by the Inquiry on 12 May 2023 and it can be found at WIT-94966 to WIT-95180. Annotated by the Urology Services Inquiry.

Witness Statement of: Sharon Glenny

I, Sharon Glenny, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

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

1.1 The SHSCT was formed in April 2007. At that time, I was working as temporary project manager for the implementation of the urology ICATS model until July 14 July 2007. My main duties and responsibilities of this post was to project manage the implementation of the Urology Integrated and Clinical Assessment & Treatment Service (ICATS) model in order to ensure the successful implementation and roll-out of the model across the Southern Trust area.

Urology Services Inquiry

well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: Sharon Glenny

Date: 1st November 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

According to an email (see TRU-320009 to TRU-320010) received by the Inquiry on 17 May 2023 the date highlighted below should read April 2023. Anotated by the Urology Services Inquiry.

USI Ref: Notice 98 of 2022

Date of Notice: 26th September 2022

Addendum Witness Statement of: Ms Sharon Glenny

I, Sharon Glenny, wish to make amendments and additions to my response to Section 21 Notice Number 98 of 2022. These are as follows:-

1. At paragraph 5.4(c)(iv) (WIT-81733), I have stated '*I provide operational support to the AD and HOS within IMWH Division –Caroline Keown (AD), Wendy Clarke, HOS for IMWH'*. This should state '*Following a temporary structure change in April 2022 agreed by the then Director, Trudy Reid, to permit my role to focus on Cancer and Clinical Services only (see attachment 1. 20221216 – Email trail re 4th OSL post), I no longer provide operational support to the AD and HOS within IMWH Division. This is now being provided on temporary basis by Carolyn Beck who took up post on 3 April 2023'.*

2. At paragraph 8.2 (WIT-81741*), I have stated ' The last KSF/PDP I had was on 25 June 2018 when I was OSL in SEC, carried out by Heather Trouton, AD at the time. However, due to operational and COVID pressures I have not had a performance review undertaken since that time, but have a date for this to be completed on 9 November 2022 with Barry Conway, AD for CCS.'* This should state '*The last KSF/PDP review I had was on 17th November 2022 with Barry Conway, AD for CCS. Prior to this due to operational and COVID pressures I have not had a performance review undertaken since 25 June 2018 when I was OSL in SEC, carried out by Heather Trouton, AD at the time. Please see attachment 2. 20221117 S Glenny KSF & PDP.*

3. At paragraph 10.6 (WIT-81743), the table is incorrect as the numbers in the second column should be swapped with the third column.

Urology Services Inquiry

Statement of Truth

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

Signed: [redacted]

Date: 12th May 2023

45. 20220915 Q10 August Cancer Performance Report

46. 20220915 Q10 Cancer Performance Meeting Action Log

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 As stated in questions 7 and 10, it is the OSL's responsibility to monitor performance. There are a number of systems in place to ensure these standards are being met which includes:

a) Monitoring of performance against expected levels of activity – Service and Budget Agreement (SBA) (agreed commissioned level of service by specialty area by the Trust and the Health & Social Care Board (HSCB) now known as the Strategic Performance Planning Group (SPPG), trajectories, Service Delivery Plans (SDP) which replaced SBA and rebuild plans

b) In relation to the monitoring of triage, in June 2012 I had developed an SDP monitoring report and circulated this out to the HOS for feedback. At that time the feedback from the HOS, including Martina Corrigan as HOS for urology, was that the report Katherine Robinson, Head of Acute Booking and Secretarial Services, provided gave the HOS sufficient information in relation to triage waits and urgent waits and there was no requirement on my part for any further performance reports to look at this speicifically. I have attached the email for reference as well as the SDP report. Please see:

47. 20120608 Q11 Email from MC re SDP update and KR reports

48. 20120608 Q11 SDP Update

Urology Services Inquiry

Temporary Project Manager - Urology ICATS Model – Band 6

16 October 2006 to 22 July 2007

4.2 The key duties and responsibilities of this post are set out in the referenced job description and in summary these were as follows:

a) To project manage the implementation of the Urology Integrated and Clinical Assessment & Treatment Service (ICATS) model in order to ensure the successful implementation and roll-out of the model across the Southern Trust area.
b) Develop a project plan, monitor progress and compliance to the plan within the set timescales
c) Co-ordinate the commissioning and set up of accommodation and facilities to support the model
d) I reported to Lesley Leeman, Operational Performance Manager within the Acute Operations Team.

Please see:

1. 200608 Q4 JD Temporary Project Manager – Urology ICATS Model

Operational Support Lead for Surgery & Elective Care (SEC) – Band 7

15 July 2007 to 31 March 2016

4.3 SEC includes the following specialty areas - General Surgery (GSUR), Endoscopy, Breast Surgery (BSUR), Urology (URO), Ear Nose & Throat (ENT), ophthalmology (OPHTH), orthodontics, oral surgery (OSUR) and Trauma & Orthopaedics (T&O). The key duties and responsibilities of this post are set out in the referenced job description and in summary these were as follows:

a) Responsible for monitoring the day-to-day operational functions associated with performance via management of primary target lists (PTLs) and waiting list management processes.

c) I had responsibility for the A&C staff within the CCS Division, who reported directly to the SAs. The SAs reported directly to myself.

d) During this tenure I reported to the Assistant Director (AD) for CCS & IMWH, firstly Heather Trouton (April 2016 to May 2018 and then Barry Conway June 2018 to date).

Please see:

2. 200608 Q4 JD Operational Support Lead – Acute Services

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

5.1 The systems within Acute Services Directorate fall under four broad areas of responsibility – Performance, Governance, Human Resources and Finance and this system is followed down through the management structure from the Director of Acute Services, to Assistant Directors, Heads of Service, Operational Support Leads and Departmental Leads. I follow the same approach in the management of my team.

5.2 Some of the key thinks covered by these systems are:

1. **Performance** - Monitoring of performance against Department of Health targets (activity and waiting times) for out-patients, in-patients, day cases, cancer targets and diagnostic services and exploring opportunities for non-recurrent funding bids in order to increase capacity within the service

2. **Governance** – Review of incidents, risk registers, complaints and compliments

3. **Human Resources** – Review of staffing levels, reporting on absence levels (sickness, vacancies, maternity leaves), review of mandatory training.

10.1 For both of my OSL tenures there have been a number of performance indictors to measure performance within my role. While it was the Divisional responsibility to monitor performance for their specialty areas, it was the Trust's Performance Team's responsibility to monitor the Trust's performance. The main point of contact for Acute Services was and remains Lynn Lappin, Head of Performance for the Trust from 2011 (Lesley Leeman, Head of Performance 2007 – 2011).

10.2 Performance objectives for the delivery of out-patient, elective, diagnostic and cancer services are set by the Minister of Health and outlined in the Integrated Elective Access Protocol (IEAP) which was implemented in April 2008. These Department of Health targets have not changed since 2008, however, the monitoring arrangements of the targets has changed and varied over time. Initially the OSLs in the Division, in conjunction with the Trust's Acute Performance Team, monitored performance against the commissioned level of clinical activity as agreed by HSCB (now Strategic Performance Planning Group 'SPPG') against the actual out-turn of activity, known as Service Baseline Agreement (SBA). SBA was the monitoring arrangement between 2013/2014 fiscal year until March 2017 when this changed to trajectory monitoring of services. Since the covid pandemic, the Trust are now being monitored against rebuild plans.

10.3 The IEAP departmental waiting time targets are summarised below and are monitored by the Trust's Performance Team and also by the OSLs for each specialty.

a. Outpatients 9 weeks from receipt of first referral appointment;
b. Elective inpatient/day cases 13 weeks from date a patient is added to the waiting list;
c. Cancer targets:
    i. 14 days – 100% for the 2 week wait breast symptomatic outpatient appointment;
    ii. 31 days – 98% from date decision to treat to first definitive treatment;

iii. 62 days – 95% date of receipt of referral to first definitive treatment.

d. All referrals will be prioritised within a maximum of three working days of date;

e. Red flag referrals require daily triage.

f. Diagnostic 9 week wait from receipt of referral.

10.4 At the point of handing over my OSL for SEC tenure to Wendy Clayton in April 2016 the waiting times for the urology specialty in particular were:

a) 74 weeks for an out-patient appointment

b) 120 weeks for an in-patient/day case elective procedure

10.5 Martina Corrigan remained the Head of Service for Urology at that time and the AD changed from Heather Trouton to Ronan Carroll. The attached documents detail the expected year end summary position for all specialties within SEC, including urology, please note that I had started to copy Wendy Clayton and Ronan Carroll into these emails in preparation for the handover of service. Please see:

30. 20160225 Q10 Email regarding SEC SBA Year End Summary

31. 20160225 Q10 SBA Year End Summary Projections

32. 20160307 Q10 Email regarding performance update

33. 20160307 Q10 SEC Performance Update

10.6 With reference to urology, out-patient referrals to the service over a number of years have been much greater than the number that the service was commissioned to deliver, leading to a demand and capacity gap as demonstrated in the table below:

Fiscal Year	Yearly Commissioned Urology New Out-Patient Activity	Total Urology New Out-Patient Referrals Received	Gap
2016/17	5121	3588	-1533
2017/18	5965	3588	-2377
2018/19	6427	3588	-2839
2019/20	6136	3588	-2548
2020/21	4484	3588	-896
2021/22	4824	3588	-1236

Urology Services Inquiry

10.7 This has had an impact on the waiting times for first appointment and the number of patients waiting beyond IEAP targets. Issues around capacity challenges, including urology capacity challenges, are discussed at monthly HOS performance meetings with the AD present. Notes of the HOS meetings were taken by the Admin Support and have been submitted for evidence in the original evidence gathering exercise. These issues are also discussed at the monthly Acute SMT Performance Meeting when performance risks are presented by the Head of Performance, Lynn Lappin, to the Director of Acute Services (Joy Youart, Gillian Rankin, Deborah Burns, Esther Gishkori, Melanie McClements and now Trudy Reid).

10.8 The table below, which is populated by the Trust Performance Team, demonstrates the volumes of patients on urology waiting lists and the longest waiting patient at each year end from 2013/14 onwards. Unfortunately, the Trust Performance Team only started collecting this information, which is a point in time position on waiting lists, for the year ending 2013/14.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	@ June 2022/23
Outpatent Waiting List	1184	1782	2714	2562	2988	3754	4041	4819	4616	3982
Longest Wait	61 Weeks	46 Weeks	74 Weeks	76 Weeks	114 Weeks	167 Weeks	217 Weeks	269 Weeks	321 Weeks	334 Weeks
Inpatient Waiting List	409	413	505	623	803	899	1014	1073	1047	1014
Longest Wait	72 Weeks	96 Weeks	201 Weeks	165 Weeks	217 Weeks	269 Weeks	295 Weeks	347 Weeks	399 Weeks	412 Weeks
DayCase Waiting List	640	435	465	872	954	838	686	990	1039	1105
Longest Wait	64 Weeks	84 Weeks	116 Weeks	161 Weeks	204 Weeks	257 Weeks	309 Weeks	361 Weeks	398 Weeks	411 Weeks
Review Backlog	Not Available	Not Available	2021	1636	2234	2716	2832	2295	1368	1361
Longest Wait			Jan-13	Aug-13	Sep-14	Apr-15	Apr-15	May-15	Jul-13	Jul-13

10.9 As OSL for CCS, I would have responsibility for the monitoring of performance against the cancer access standards as set out above and providing the Operational ADs and HOS information regarding performance so that they can discuss the operational challenges with their respective clinical teams. The tables below summarise the fiscal year end position for the urology tumour site compared with the Trust overall cancer performance against the 31 and 62 day cancer performance targets during my tenure as OSL for CCS (1 April 2016 to date).

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62 Day Cancer Performance Target = 95% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	83.93%	81.91%
2017/2018	74.29%	58.43%
2018/2019	74.33%	54.41%
2019/2020	65.92%	41.59%
2020/2021	60.75%	32.10%
2021/2022	49.75%	27.13%

31 Day Cancer Performance Target = 98% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	99.00%	100.00%
2017/2018	97.14%	99.70%
2018/2019	99.50%	99.41%
2019/2020	98.17%	98.93%
2020/2021	92.42%	94.65%
2021/2022	85.67%	97.81%

10.10 Up until 4th January 2022, the Cancer Services Co-Ordinator was responsible for escalating all delays on the cancer pathway including first red flag appointments, delays with diagnostics, delays with first definitive treatment. When I came into post on 1st April 2016 the Cancer Services Co-Ordinator was Vicki Graham (to 9th August 2020), Sinead Lee (10th August 2020 to 25th October 2020 (temp)), Ciaran McCann (26th October 2020 to 31st March 2021 (temp)) and Sinead Lee (1st April 2021 to date). These escalations were sent to the Operational HOS who was charged with directing steps to address the concerns. However, it is recognised that at times minimal action could be taken due to ongoing capacity and demand difficulties within specific tumour sites, including urology With reference to Urology, there have been capacity and demand difficulties across the whole cancer pathway throughout my tenure as OSL for CCS, including delays with first appointment, delays with diagnostics i.e MRI, PET scan (Regional service provided in Belfast) and flexible cystoscopy, Transperineal (TP) biopsy, and delays with surgery. The actions that have been taken by HOS, including urology, around escalations of patients on cancer pathways include:

a) Increasing red flag out-patient capacity on clinic templates
b) Offering in-house additionality to increase overall out-patient capacity
c) Working with other Trusts to equalise waiting times, in particular for transperineal biopsy
d) Securing Independent Sector capacity in relation to out-patient capacity and flexible cystoscopy

c) I also attend the **Acute SMT Performance Meeting** monthly which is chaired by the Director of Acute Services (Esther Gishkori, then Melanie McClements and now Trudy Reid) when the Trust's Performance Team attended and gave an overview of Acute performance which includes urology. These meetings are attended by all ADs and OSL – the HOS are not usually in attendance at these meetings unless covering for the AD.

d) There are **bi-monthly Cancer Performance Meetings with SPPG** (formerly known as HSCB). At this meeting cancer performance is reviewed for all tumour sites, including urology. These meetings are attended by SPPG representatives including the chair (Lisa McWilliams, Director of Stategic Performance) Trust Performance Team representatives (Lynn Lappin, Head of Performance and Lesley Leeman, Assistant Director Performance Improvement) Director of Acute Services (Esther Gishkori, then Melanie McClements and more recently Trudy Reid), Operational ADs, HOS and OSLs. There was a power point presentation prepared by SPPG in advance of the meeting, but no formal notes taken at the meeting.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 As outlined in Q19, my role as OSL in both tenures is relevant to the operational monitoring of performance targets within urology services. My roles and responsibilities on a day-to-day basis are structured around the preparation of performance dashboards and reports, monitoring trends, highlighting risk and making bids for additional resource (non-recurrent funding) to reduce access times for patients.

21..2 As OSL, I had no role in the monitoring of untriaged referrals as the responsibility for this sat with Katherine Robinson (Head of Acute Booking and Secretarial Services)

internally and externally, that there are significant capacity and demand gaps within the urology service and recognised Regionally that there was significant challenges and limitations to what could be done to improve access for patients. The waiting times position for urology would also have been discussed at Acute SMT Performance Meetings and also a the HSCB/SPPG Elective Performance Meetings.

(ii) Triage/GP referral letters

26.2 As OSL for SEC up to 31 March 2016, I escalated on a number of occasions the delays with untriaged referrals. This was escalated to the HOS, Martina Corrigan, but I would not be aware of what the action and outcome was from these escalations.

26.3 In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics

(iii) Letter and note dictation

26.4 I do not recall raising any concerns in relation to letter and note dictation and I have no recollection of any concerns being raised to me by any A&C staff within the urology specialty. In relation to delays with dictated triage information, unfortunately I do not recall this ever being raised with me as an issue by the secretarial staff during my tenure as OSL for SEC.

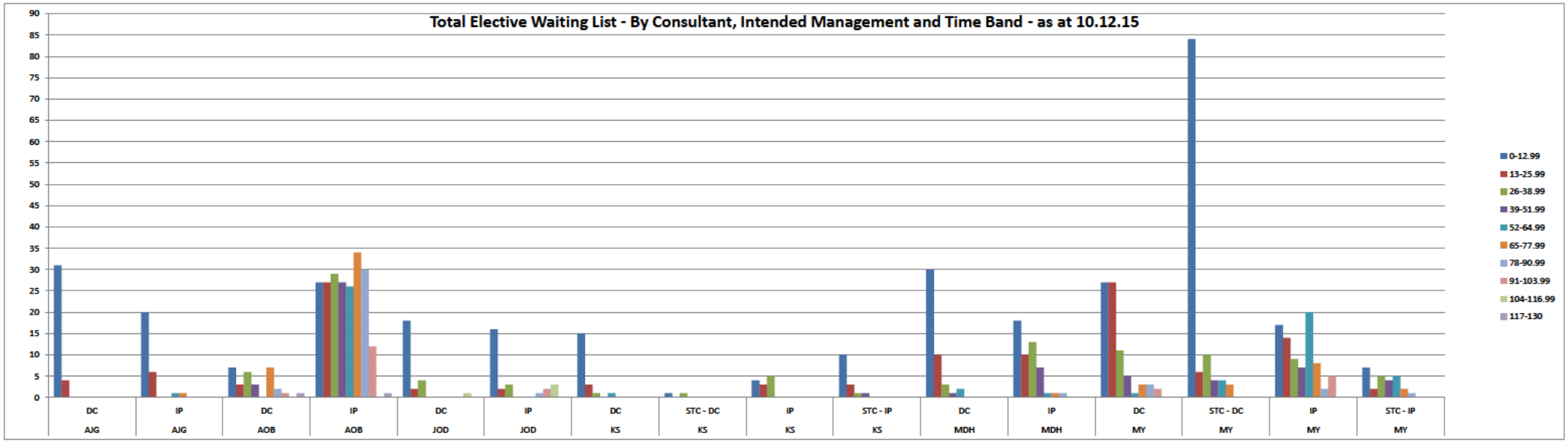
(iv)Patient care scheduling/Booking

26.5 As the scheduling of elective patients for urology took place in a team scheduling meeting, with all consultants taking part in the scheduling of patients and sharing of patients across consultant theatre lists for chronological management of patients in urgency order, I didn't have any concerns.

(v) Prescription of drugs

TOTAL UROLOGY ELECTIVE WAITING LIST - EXCLUDES PATIENTS WITH DATES AND SUSPENDED PATIENTS - AS AT 10.12.15
(Potential STC patient volumes identified separately)

		WEEKS WAITING (13 WEEK BLOCKS)											
Consultant Code	Intended Management	0-12.99	13-25.99	26-38.99	39-51.99	52-64.99	65-77.99	78-90.99	91-103.99	104-116.99	117-130	TOTAL	GRAND TOTAL
AJG	DC	31	4	0	0	0	0	0	0	0	0	35	63
AJG	IP	20	6	0	0	1	1	0	0	0	0	28	
AOB	DC	7	3	6	3	0	7	2	1	0	1	30	243
AOB	IP	27	27	29	27	26	34	30	12	0	1	213	
JOD	DC	18	2	4	0	0	0	0	0	1	0	25	52
JOD	IP	16	2	3	0	0	0	1	2	3	0	27	
KS	DC	15	3	1	0	1	0	0	0	0	0	20	49
KS	*STC - DC*	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*2*	
KS	IP	4	3	5	0	0	0	0	0	0	0	12	
KS	*STC - IP*	*10*	*3*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*15*	
MDH	DC	30	10	3	1	2	0	0	0	0	0	46	97
MDH	IP	18	10	13	7	1	1	1	0	0	0	51	
MY	DC	27	27	11	5	1	3	3	2	0	0	79	298
MY	*STC - DC*	*84*	*6*	*10*	*4*	*4*	*3*	*0*	*0*	*0*	*0*	*111*	
MY	IP	17	14	9	7	20	8	2	5	0	0	82	
MY	*STC - IP*	*7*	*2*	*5*	*4*	*5*	*2*	*1*	*0*	*0*	*0*	*26*	
TOTAL		332	122	101	59	61	59	40	22	4	2	802	



Received from SHSCT on 02/11/2022. Annotated by the Urology Services Inquiry.

1.6 During my tenure as OSL for SEC (July 2007 to March 2016), there was an apparent issue with untriaged letters within urology, particularly with Mr O'Brien. As OSL for SEC, I escalated concerns from the Referral & Booking Centre (RBC), to the Head of Service (HOS), Martina Corrigan. The RBC, under the management of Katherine Robinson, had a process in place to escalate delays in triage outcome to all of the OSLs. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain to the appropriate HOS. It was the HOS who was charged with directing steps to address these concerns. In relation to urology, it was my understanding that the HOS, Martina Corrigan, would have discussed the concerns with the clinical team and/or consultant directly, either face to face or by email, although I would not normally have been aware of the outcome of these discussions as that was not normally fed back to me. I would not have followed up on these discussions as that was outside the scope of my role as OSL.

1.7 In my current tenure of OSL for CCS & IMWH, I monitor performance against the cancer against targets which is presented at the monthly Cancer Performance Meetings to the operational HOS, ADs and OSLs who have responsibility for the delivery of cancer services across the tumour sites. These meetings are also attended by the Director of Acute Services as well as representatives from the Trust Performance Team. Unfortunately, throughout my current OSL tenure, the Trust has been unable to deliver the 31 and 62 day cancer access targets across a range of tumour sites, including urology. The monthly cancer performance meetings are used to review cancer performance across all tumour sites, including urology and a record of the internal and external risk areas recorded. Any actions agreed will be noted and this will be reviewed at the next meeting.

1.8 The CCS Division has responsibility for the co-ordination of the cancer multi-disciplinary meeting (MDT) and tracking of patients on 31 and 62 day pathways from the date of referral until first definitive treatment, using the Cancer Patient Pathway System (CaPPs). The red flag appointments team/cancer tracking team ought to escalate delays

Glenny, Sharon

From: Glenny, Sharon [redacted]
Sent: 25 November 2013 15:59
To: Corrigan, Martina
Subject: FW: untriaged referrals - UROLOGY

Importance: High

Hi Martina

I know this has already been escalated to you, but do you think we are at the point where we need to permit RBC to send for these patients despite not being triaged? May mean we have some consultant clinics with LUTS and Andrology patients, but rather than lose any more reasonableness of offer do we need to consider this?

Sharon

From: Browne, Leanne
Sent: 25 November 2013 15:54
To: Glenny, Sharon
Cc: Coleman, Alana
Subject: FW: untriaged referrals

Hi Sharon

Attached is a list of untriaged Urology referrals, emailed to secretaries 11th November and Andrea 19th November.

Thanks

Leanne

From: Browne, Leanne
Sent: 19 November 2013 14:33
To: Cunningham, Andrea
Cc: Coleman, Alana
Subject: untriaged referrals

Hi Andrea

Below is a list of untraiged Urology referrals,can you please arrange for these to be triaged and returned as soon as possible.

CAH

[redacted]

[redacted]

[redacted]

[redacted]

26.6 I have never had any responsibility or input to the prescription of drugs and therefore have no concerns.

(vi) Administration of drugs

26.7 I have never had any responsibility or input to the administration of drugs and therefore have no concerns.

(vii) Private patient booking

26.8 I have never had any specific responsibility or input to private patient booking and therefore have no concerns.

(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs

26.9 In my current tenure as OSL for CCS, I have management responsibility for the cancer tracking team who support the MDT meetings and take note of the MDM attendance and record the outcomes. These staff reported to the Cancer Services Co-Ordinator (initially Vicki Graham, then Ciaran McCann and now Sinead Lee) until January 2022 when there was a change in the management structure and they now report to the Cancer MDT Administrator, Angela Muldrew. Both the Cancer Services Co-Ordinator and Cancer MDT Administrator report to me in the CCS management structure. Any concerns regarding delays with urology patients on the cancer tracking pathway are escalated to the HOS by the Cancer Services Co-Ordinator/Cancer MDT Administrator for review and action (formerly Martina Corrigan and now Wendy Clayton), It is the HOS who is charged with directing steps to address the concerns. As OSL for CCS, I would not always be copied into escalations and therefore would not always be copied into the response from HOS. However, if no corrective action was taken, the same patients would be escalated in the next round of tracking as described above.

26.10 Since becoming a member of the Task and Finish Group led by Sarah Ward, Head of Clinical Assurance for the Public Inquiry, I am now aware of quoracy issues within the Urology MDT Meeting, specifically around lack of representation of radiologists,

delayed I have raised the concern with Mr Young who is the clinical lead and he was happy for me to proceed on authorising the Red Flag Team to appoint these patients without Mr O'Brien's triage. I can't afford to wait with red flag referrals.

11. Mr O'Brien's practice is very different to that of all the other Urologists. On occasion I may have to chase up 1 or 2 outstanding referrals from the other Consultants. I have in the past run lists from PAS for Mr O'Brien's referrals and there may have been 20, 30 or 40 outstanding letters. Sometimes after escalating to him, Mr O'Brien would have a burst of returning them and I would get responses from him, but in the main I didn't get a response.

12. I escalated these concerns to Eamon Mackle and Heather Trouton over the years. I know the issue would have been addressed with Mr O'Brien verbally but I suspect it was never in writing to him. I know it was verbally addressed by Eamon Mackle, Paddy Loughran, John Simpson and more recently Dr Wright. I am aware that on one occasion after Mr Mackle addressed the concerns with Mr O'Brien that Mr O'Brien made an allegation and complaint of bullying by Mr Mackle. As a result of this from Mr O'Brien, Mr Mackle was told to back off. After that Mr Mackle didn't try to address the concerns again.

13. After continuously not getting a response from Mr O'Brien I agreed that the patients should be added to the outpatients waiting list according to the category that the GP had assessed the patient as being . I had met with Anita Carroll and Katherine Robinson and agreed this and Heather Trouton as my AD had confirmed that she was happy with this. At that time the waiting lists had shorter waiting times and were more manageable however, this has changed and the waiting times have become much longer. At one point there was a plan to use available monies to get patients seen out of hours. When all routine and urgent referrals started to be added to the waiting list as per GP category I was no longer able to run a report which showed what patients had not been triaged. It was agreed by Debbie Burns, Heather, Anita, Katherine and I that the attempts to get the triage done didn't work so we needed a way of ensuring that patients were at least on a list so that they were not disadvantaged chronologically. Because by being on this list then we were assured that they were then always allocated an appointment when it was their turn By adding these patients to the waiting list it looked as if they had been triaged so it wasn't being escalated to me anymore .

14. Mr O'Brien complained he didn't have time to do triage because of his patient care or admin commitments. He was offered help and I know at one point Mr Young took his triage for about 8 months. Mr O'Brien would always have said he was determined to give 'a rolls royce service' to his patients and my view along with others was; 'but what about all the patient's you don't see?' I know he felt this wasn't his responsibility. He wanted to do advanced triage but that wasn't what was agreed and there wasn't time for that, so he didn't get much of the triage done at all.

15. Mr O'Brien said he needed 30 mins consultation with each patient. BAUS guidelines set out that appropriate time for review patients is 10 minutes and 20 minutes for new patients. To accommodate Mr O'Brien, clinics were set up with less patients for him on each of the clinics he

awaiting funding from the Commissioner (HSCB/SPPG) and the post holder is expected to be in post by end November 2022. In the meantime, the Cancer MDT Administrator has undertaken a snap shot audit in April/May 2022 of a random sampling of patients who had been discussed at the Urology MDT in January 2022 and this has been referenced in the attachment below. Reassuringly, this audit demonstrated that all outcomes agreed were actually followed through. The audit was discussed at the Urology MDM on 12 May 2022, minutes of which are attached for reference. Please see:

103. 202205 Q39 Urology MDM Outcome Audit of January 2022

104. 20220512 Q39 Urology MDM Minutes

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

40.1 As OSL in CCS, there were a number of issues of concern raised through the Task & Finish Group that relate to the delivery of cancer services, in particular the Urology Cancer MDT. The Macmillan Service Improvement Lead (Mrs Mary Haughey) has also undertaken a National Cancer Team (NCAT) MDT baseline assessment on all tumour sites during 2021, including urology, and a service improvement action plan has been developed to improve the effectiveness of MDTs which has been referenced below. I have been working closely with my AD (Barry Conway), HOS for Cancer (Clair Quin) and the Macmillan Service Improvement Lead (Mary Haughey) to bring forward changes within the service, set out in the attached action plan. Please see:

105. 202206 Q40 MDT Service Improvement Action Plan

40.2 On reflection, the learning is that Mr O'Brien does not appear to have been held to account for his processes around untriaged referral letters and this practice was able to

continue as I have referenced the continuing escalations of untriaged referral letters in my response.

40.3 Also, on reflection, I believe there was insufficient audit of MDT processes, ensuring the agreed action from MDT discussion was actually undertaken. This lack of audit is not unique to SHSCT as it would be my understanding that other Trusts are in a similar position due to lack of commissioned resource.

40.4 As OSL in both tenures, I have not been involved in any of the processes looking into Mr O'Brien's practice and any investigation would be considered confidential.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1 I was aware of performance difficulties for urology services during my tenure as OSL in SEC as outlined in my response to Question 7 and Question 10. The increase in referrals to the service would have led to capacity and demand challenges against the commissioned level of service. I do feel in relation to performance that there was full engagement with myself, the clinical team, HOS (Martina Corrigan), AD (Simon Gibson then Heather Trouton) to raise these issues with HSCB (now SPPG).

41.2 In relation to the concerns around untriaged referrals, my role as OSL in SEC (July 2007 to March 2016) was to escalate to the HOS (Martina Corrigan) which I did consistently throughout my tenure. I was copied into at least one onward escalation to the AD (Heather Trouton) regarding these concerns. Given that the escalations

referrals to the Operational HOS for action (then Martina Corrigan and now Wendy Clayton).

24.4 Ultimately, responsibility for triage rests with the clinical team, ie, the consultants. During my OSL tenure in SEC, I was not directly involved with the administrative process around the sending and returning of triage outcomes. Staff in RBC sent the referrals for triage directly to the secretarial staff who then printed off for the consultant's attention and once triaged, these were returned with the outcome to RBC. The secretarial staff provided a support mechanism for drawing the untriaged referrals to the attention of the consultant for action. Unfortunately I do not recall the secretarial staff ever raising concerns with me regarding issues around untriaged referral letters from the process described above.

24.5 However, it was apparent from the report produced by Katherine Robinson and her team in the RBC that there were delays in triage across the specialties, particularly in urology and with Mr O'Brien and I received the escalation of untriaged referral letters from the Referral & Booking Centre. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain, ie., raised with the appropriate HOS and it was the HOS who was charged with directing steps to address these concerns. It was my understanding that the HOS (Martina Corrigan) would have discussed the concerns with the clinical team and/or consultant directly either face to face or by email, although I would not normally have been aware of the outcome of those discussions as that information was not normally fed back to me. I would not have followed up on these discussions as that was outside the scope of my role as OSL.

(iii) **Letter and note dictation**

24.6 During my tenure as OSL for SEC from 1 April 2007 to 31 March 2016, I had responsibility for the A&C staff within the Division until 31 May 2013, which included urology. Following this time, the line management responsibility of the secretarial and

audio-typing staff in SEC moved to Katherine Robinson, Head of Acute Booking and Secretarial Services Head of Admin and the ward clerk staff moved to Helen Forde, Head of Health Records. Up until that time, the urology secretaries and audio-typists would have reported directly to the SA who in turn reported to me. The SA and I would have kept the HOS informed of any backlogs with letter and note dictation and produced A&C risks matrix detailing the backlogs by secretary. This was completed for all secretaries, including urology as referenced the attached email and report.

24.7 In relation to delays with dictated triage information, I do not recall this ever being raised as an issue with me by the secretarial staff. Please see:

97. 20120618 Q24 Email re A&C SEC Backlog Risks Matrix
98. 20120618 Q24 A&C SEC Backlog Risks Matrix Report

(iv) **Patient care scheduling/Booking**

24.8 As per my response to Question 24(i), we had a urology rota and planning meeting where patients were scheduled for surgery. The secretaries were in attendance at that meeting and were then responsible for actual scheduling of the patients on PAS and adding the patients to theatre lists. Out-patient appointments were booked by the Referral & Booking Centre.

(v) **Prescription of drugs**

24.9 I have never had any responsibility or input to the prescription of drugs.

(vi) **Administration of drugs**

24.10 I have never had any responsibility or input to the administration of drugs.

(vii) **Private patient booking**

24.11 I have never had any responsibility or input to private patient booking.

w/c 18/06/2012					BACKLOG IN CHART/RESULT VOLUMES											
SPECIALTY/ WARD/AREA	CONSULTANT	SECRETARY/ WARD CLERK	AUDIO-TYPIST	SITE	CLINICS (Pts)	FURTHEST DATE BACK	DISCHARGES to be typed (including ward attenders)	DISCHARGES to be dictated	RESULTS to be typed (Se)cs) or filed (ward clerks	RESULTS TO BE DICTATED	CHARTS AWAITING RESULTS / ACTION DELAYED	TOTAL VOLUME OF CHARTS/ RESULTS TO BE TYPED	MEDICAL TOTAL VOLUME OF CHARTS/ RESULTS AWAITING DICTATION	TOTAL BACKLOG OF FILING	DARO REPORT UPDATED	RISK
GSUR	MR MACKLE	Cathy	Sinead shared with Janice & Cathy	CAH	41	11/06/2012	0	10		28	4	**41**				
	MR MANOS	Sarah	Vacant	CAH and STH	31	07/06/2012	50	30	0	75	230	**81**				
	MR LEWIS	Pat	Cheryl	CAH and STH	0		0	0	0	0	0	**0**				
	MR WEIR	Jennifer	None	CAH and ACH	19	CAH 14.06.12	0	49	31	6	84	**50**		1/2 Lever Arch File	18.06.12	
	MR MURUGAN / MR MCKAY	Ruth	None	CAH and STH	15	14.06.2012	21	38	9	12	118	**45**				
	MR HEWITT	Janice	Sinead shared with Janice & Cathy	CAH and STH	0		0	0	0	0	0	**0**				
	MR YOUSAF	Shirley	Sinead shared with Janice & Cathy	CAH and STH	0		20	40	50	0	0	**70**				
TOTAL GSUR					**106**		**91**	**167**	**90**	**121**	**436**	**287**	**0**			
TOTAL BSUR	**MR MCFALL (including staff grades)**	**Sharon**	**Amy**	**CAH**	**81**	**12/06/2012**	**0**	**Awaiting charts from wards**	**20**	**0**	**251**	**101**		**3 full trays of filing**		
UROLOGY	MR YOUNG	Paulette Dignam	Amanda	CAH	0	00/01/1900	0	0	113	36	15	**113**	**155**	Approx 1.5 lever arch files of filing a log of which are oncology letters.		
	MR O'BRIEN	Monica McCorry	Sara/Pat	CAH	64	15/06/2012	75	75	23	18	0	**162**	**0**	5 Lever Arch Files - Concerns about oncology letters not being filed		
	MR HO	Liz Troughton	Claire	CAH	10	13/06/2012	0	64	0	36	80	**10**	**0**	4.5 File Blocks		
	NURSE/ICATS	Leanne Hanvey	None	CAH	0		0	0	0	0	0	**0**	**0**	No Backlogs		
TOTAL UROLOGY					**74**		**75**	**139**	**136**	**90**	**95**	**285**	**155**			
ENT	MR MCNABOE	Angela Mulholland	June	CAH	0		0	0	0	0	0	**0**	**0**	No Backlogs		
	MR HALL	Pamela Hamilton	Caroline	CAH	30	07/06/2012	55	25	0	20	25	**30**	**45**	2 BOX FILES FULL +++		

From:	Carroll, Ronan
To:	Wright, Richard; Kerr, Vivienne; Gishkori, Esther; Gibson, Simon; Boyce, Tracey
Subject:	FW: Backlog report - no clinic outcomes
Date:	23 December 2016 10:24:54
Attachments:	Backlog Report - no clinic outcomes as per 15.12.16.xlsx
Importance:	High

Please see updated position re AoB backlog of undictated clinics

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off sick recovering.

Regards

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

from radiology and oncology consultants. It would be my view that these gaps would have resulted in patients being deferred from MDT discussion, thereby making the MDT discussion ineffective. Examples of patients between deferred from MDT discussion are highlighted in the attached MDM Update Reports from 17 February 2022 and 16 June 2022. Please see:

80. 20220217 Q22 Update Report from Urology MDM
81. 20220616 Q22 Update Report from Urology MDM

22.7 In my role as OSL for CCS, the cancer tracking team report to me via the Cancer Services Co-Ordinator, and more recently via the Cancer MDT Administrator. It has been my view over a number of years that the cancer tracking team were inadequately staffed and inadequately funded by HSCB/SPPG to fully track the volume of patients on cancer pathways. As with all other Trusts in the Region, we currently track patients to first definitive treatment only on cancer pathways, that is, if a patient requires onward treatment and cancer support, no Trust is funded to support this level of tracking. Please see:

82. 201908 Q22 Cancer Pathway Escalation Policy Final

22.8 In August 2018, Cara Anderson, Assistant Director of Commissioning in HSCB undertook an analysis of the demand and capacity on the cancer tracker resource across all five Trusts. This analysis demonstrated that there were considerable gaps across the Region with a total of 16 whole time equivalent (wte) Band 4 cancer tracker/MDT co-ordinator gap, SHSCT had a gap of 4.7 wte. The conclusion at that time was that SHSCT required 8.6 wte to track patients on cancer pathways to first definitive treatment. This report has been attached and referenced below. Please see:

83. 201808 Q22 HSCB Cancer Tracking Resource Analysis of Capacity and Demand

Urology Services Inquiry

4. At paragraph 22.15 (WIT-81765), I want to add '*All posts within the Cancer Tracking Team are now funded by SPPG, 11.6 wte funded recurrently and 2.43 funded non-recurrently. On 24 January 2023 the Trust received an allocation letter of £106,404 CYE increasing the tracking staff by 3.0 wte recurrently (please see 3. 20230124 Cancer tracking SHSCT). Subsequently, the Trust then received a further allocation letter on 3 February 2023 recognising that the Trust had gone at risk to appoint 5.43 cancer trackers, the allocation letter of 24 January 2023 had confirmed recurrent support for an additional 3 wte and in recognition of the on the ground pressure, this letter confirmed that SPPG would make available a further non-recurrent allocation of £86,187 CYE to close the gap (please see 4. 20230203 Alloc letters Cancer Strategy slippage SHSCT).*

5. At paragraph 22.17 (WIT-81765), I want to add '*The Cancer Information & Audit Officer is now in post, Mark Quinn commenced on 28 November 2022'.*

6. At paragraph 19.3 (WIT-81757), I have stated '*The Referral and Booking Centre, under the management of Katherine Robinson, Head of Acute Booking and Secretarial Services had a process in place to escalate delays in triage outcomes to the OSLs*.' I want to add to references after this sentence. '*Please see 16. 20140217 - email re triage of referral process from AC and 17. 20140217 email re triage of referral process from AC A1.'*

7. At paragraph 26.3 (WIT- 81775), I have stated "*In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics*." This should state "*In order to mitigate risk, I was informed by Martina Corrigan (HOS for urology) that a decision was taken to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics. I am unsure of the exact date, but it was sometime around April 2014. Anita Carroll, Assistant Director for Functional Support Services, had stated in her email at point 6 above (16. 20140217 – email re triage of referral process from AC) that she had suggested to Heather Trouton 'that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week'"*

Terms of Reference- Agreed by Group 11 October 2021

Trust's Task and Finish Group into Urology SAI Recommendations

Terms of Reference of Task and Finish Group

The Task and Finish group is charged with implementing all the recommendations and providing assurance/evidence to the Urology Oversight Group

Membership of Task and Finish Group

Consultant	Nurse	Manager/Admin
Philip Murphy, Deputy Med Director Shahid Tariq, Deputy Med Director Mark Haynes – Deputy Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, Gen Surgery Kevin McElvanna General Surgery Art OHagan Dermatology Geoff McCracken, Gynae Helen Mathers Breast Rory Convery Lung Christina Bradford;, Hematology Anthony Glackin,; Urology Marian Korda, ENT	Clair, Quin, Cancer Lead Tracey McGuigan, Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Service Improvement Lead Sharon Glenny, performance manager Jane Scott performance manager Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Sarah Ward, Head of Service Clinical Assurance

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-disciplinary teams to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Life span of Task and Finish Group

The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.