Southern Health and Social Care Trust

Quality Care - for you, with you

UROLOGY SERVICES INQUIRY

USI REF: Notice 5 of 2021

DATE OF NOTICE: 4 February 2022

WITNESS STATEMENT OF: Joseph Shane Devlin

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

SIGNED: 

DATE: 4 February 2022

Addendum to Section 21 Notice — No 5

I Joseph Shane Devlin confirm that Appendix 37 should be referenced at the end of paragraph 3 Question 69 page 76.

In Question 54 on page 65 and in Question 71 on page 79 references to Appendix 45 should refer to Appendix 47.

Signed: 

Date: 11th February 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 45 of 2022
Date of Notice: 29 April 2022

Witness Statement of: Joseph Shane Devlin

I, Joseph Shane Devlin, will say as follows:-

[1] Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, 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 using the form provided.

1. Having regard to the Terms of Reference of the Urology Services Inquiry, I set out below a narrative account of my involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, *inter alia*, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's relevant investigation. I have chosen to answer all questions (from Question 4 onwards) following my account in order to give a fuller understanding of my role.

Urology Services Inquiry

[15] Having had the opportunity to reflect, outline whether in your view the MHPS process have been better used in order to address the problems which were found to have existed in connection with the practice of Mr. O'Brien.

37. Given that I only took up post as Chief Executive in March 2018, my knowledge of the full details of the implementation of the MHPS in the Mr O'Brien case is limited to a short timeframe. However, accepting that limitation, I feel that the points reflected in response to question 13 would reflect my understanding of the opportunities to better use MHPS to have addressed the problems.

38. On reflection, it is clear to me that the action planning and delivery process, following the production of the MHPS findings, should also have been stronger and more systematic, to ensure that agreed actions were fully delivered.

Statement of Truth

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

Signed: __ _____

Date: __24 June 2022_____

Curriculum Vitae – Shane Devlin

Name: Mr Joseph Shane Devlin (known as Shane) Mobile: Personal Information redacted by the USI
Address: Personal Information redacted by the USI E Mail: Personal Information redacted by the USI
Twitter: Personal Information redacted by the USI

Career Overview

Detailed below are the roles I have undertaken and my key achievements in the last fifteen years. In summary I have worked in various Chief Executive, Director and other senior management positions within the NHS in Northern Ireland for the last twenty two years. I have had the pleasure of continuously managing change and improvement within integrated health and social care and am very proud of my achievements.

March 2018 – Current - Chief Executive, Southern Health and Social Care Trust

Organisation Background

The Southern Trust is an integrated Trust delivering hospital and community health and social services to a population of approximately 370,000 people. The Trust has an annual budget of circa £800 million and employs approximately 13,500 staff

Roles & Responsibilities

- As accountable officer I am responsible for all elements of service delivery, quality, safety and financial viability.
- Working with the Trust Board to develop a new strategic direction for the Trust to ensure fitness for purpose into the future.
- To create the environment of compassionate leadership to enable new service models to be developed and implemented.

Key Achievements

- Successfully led the organisation through the Covid 19 pandemic. I created a rapid new management structure and process to manage the organisation in a rapid and lean manner. Within a very short period of time I reconfigured our hospital services, creating a covid hospital, and a green clean hospital. We also mobilised a home working revolution allowing hundreds of staff to function from home and created a new model of virtual clinic delivery and virtual hospital visiting.
- Designed and delivered a twelve month Trust Board Development Programme focused on improving accountability and developing a new culture and strategy through the Board.
- I designed and led a process of agreeing the key purpose and objectives for each directorate, and turning these into directorate dashboards and safety thermometers.
- As SRO for the Daisy Hill Pathfinder I lead a co-designed programme of improvement for Daisy Hill Hospital and the wider South Down community. The year 1 targets were achieved on time, and budget, and Daisy Hill Hospital is regularly the top performing hospital with regards to 4hr & 12hr performance, it has the second lowest unit cost of any NI hospital and along with Craigavon, its sister hospital, it has been recognised in the UK Top 40 hospitals award.
- I am part of the HSC Regional Management Board. This group consists of all Trust Chief Executives, DOH Permanent Secretary and Senior Departmental Officials. Collectively we are responsible for the delivery of the cross party agreed 10yr Strategy for Health and the rebuild plans following the Covid19 pandemic.

November 2016 to March 2018 - Chief Executive, Northern Ireland Ambulance Service (NIAS) Trust

Organisation Background

NIAS is the regional provider of all emergency ambulance services to Northern Ireland and the provider of the majority of non emergency ambulance services. It has a budget of approximately £84mil and 1200 employees.

Roles, Responsibilities & Achievements

- As accountable officer I was responsible for all elements of service delivery, quality and financial viability.
- To develop a new strategic direction for the Trust to ensure fitness for purpose into the future.

October 2007 – April 2009 - Assistant Director Performance and Improvement , The South Eastern Health and Social Care Trust
• As part of the new management team I was responsible for designing and implementing a new performance management and improvement process and culture. • Operationally manage information services, planning and performance management and quality improvement functions.
July 2006 – October 2007 - Seconded to the Department of Health and Social Services, Programme Manager for the Review of Public Administration (RPA)
• Successfully programme managed the changes so that 18 Trusts were reduced to 5 in line with the agreed timeframe. The total savings of phase 1 were £53 million • To develop the business case for change and secure buy in and approval from the Department of Finance and Personnel (NI Treasury)

Education and Learning Overview

I am an avid learner and my preferred learning style is very much through work based learning from experience. I constantly review my learning through regular reviews and have undertaken four 360 degree appraisals over the last seven years to evaluate, from my colleagues points of view, the learning opportunities. In addition to work based learning I have undertaken the following formal learning opportunities.

- BSc(Econ) Honours – Queens University Belfast, 1994
- Postgraduate Certificate in Management – Institute of Management, 1995
- Leaders for Tomorrow Programme – Harvard University, 1996
- Assessor - European Foundation for Quality Management (EFQM), 2001
- PRINCE2 Practitioner – The Projects Group, 2002
- The Horizons Programme, The Beeches Management Centre in Conjunction with the Kings Fund, 2010

Other Interests

In March 2019 the DOH Permanent Secretary asked me to take on the role of the SRO for a new phase of Shared Services within the HSC – Digital Shared Services. This involves the creation of a new single provider for the complete range of digital services including end user computing, hosting, networks, applications, service desk and project management. Having worked in partnership with a range of internal and external stakeholders to develop a robust and agreed blueprint we are now at the end of the development stage and are about to submit the outline business case for approval.

I am Board Member of an organisation called Co-operation and Working Together (CAWT). CAWT was established to transform socially deprived border counties on the island of Ireland through improving health and social wellbeing.

I am the Chair of the Children's and Young Persons Strategic Partnership (CYPSP). CYPSP brings together agencies, children and young people, families and communities across Northern Ireland working together - to improve outcomes for children and young people through integrated planning and commissioning

I am at governor of Brownlow Integrated College, Craigavon. This provides an opportunity to give something back to this fabulous school which has been at the forefront of driving integration within what is a socially deprived community coming out of conflict and has been historically under-funded, and under achieving.

I have also recently been appointed to the Board of the Chief Executive Forum. The Chief Executives' Forum is the association of chief executive officers of civil and wider public service bodies in Northern Ireland.

In my spare time I enjoy playing golf, gardening, cooking and walking.

Curriculum Vitae – Shane Devlin

Person Centred Community Information System Programme Manager (PCIS)
Down Lisburn Health and Social Services Trust

Organisation Background

Down Lisburn Trust was a Health and Social Services Trust providing hospital and community services to a population of approximately 180,000 employing 4000 staff.
PCIS was a regional project to support clinicians in the community through the creation of a single electronic community record.

Roles & Responsibilities

- To manage a multi-disciplinary team to develop the specification for the PCIS team
- To support the regional procurement of the system
- To develop a culture of IT literacy to support the transition to electronic records

Key Achievements

- The creation of an agreed output based specification which was agreed across all professions.
- Ensured considerable multi-disciplinary learning was achieved and over 1000 healthcare professionals develop ICT skills which were utilised in daily business

July 1998 – January 2001

Quality Improvement Manager
Down Lisburn Health and Social Services Trust

Organisation Background

Down Lisburn Trust was a Health and Social Services Trust providing hospital and community services to a population of approximately 180,000 employing 4000 staff.

Roles & Responsibilities

- As business partner to Acute services develop and implement a series of improvement actions to improve the efficiency and effectiveness of the two general hospitals within the Trust.
- As part of the Quality Support team, manage the overall quality improvement journey of the Trust

Key Achievements

- Successfully implemented quality improvements across the acute sector to include improvements in Outpatient Access, Quality and Safety in CSSD, Care Pathways in Stroke Care and the provision of rapid access to community equipment to support timely discharge from hospital.
- In January 2001 Down Lisburn Trust was awarded the Northern Ireland Quality Award. The Trust was the first, and remains the only, Healthcare Organisation to win the premier award for business excellence in Northern Ireland.

April 1995 – July 1998

Quality Award Manager
The Northern Ireland Quality Centre (NIQC), Belfast

Organisation Background

The Northern Ireland Quality Centre was created by Northern Ireland's leading organisations to

Southern Health and Social Care Trust
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JOB DESCRIPTION

JOB TITLE Chief Executive

BASE Trust Headquarters,
Craigavon Area Hospital

JOB SUMMARY

The Chief Executive is the most senior executive member of the Trust Board and leads the development of the vision for the strategic direction of the Trust in line with the overall policies and priorities of the Department of Health (DoH) and the Health and Social Care Board (HSCB).

As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DoH and HSCB and ultimately the Minister for the performance and governance of the Trust in the delivery of high quality care, responsive to the needs of the population in line with prevailing performance standards and targets.

The Chief Executive has overall responsibility for the management and performance of the Trust, including meeting Ministerial priorities as defined by the DoH and HSCB, fulfilling statutory requirements, delivering against clinical and non-clinical performance targets, securing continuous improvement and for providing safe, high quality and effective services within a clear financial framework.

The Chief Executive will lead on-going modernisation and reform within the Trust including the achievement of all organisational objectives, ensuring that appropriate, robust systems are in place and necessary changes are achieved within a transparent and effective governance framework.

The Chief Executive is responsible for ensuring the Trust delivers on its vision, values and priorities, continually aligning these to the Trust's Strategic Plan.

KEY RESULT AREAS

DELIVERY

1. Lead the development of the annual business plan for the provision of services in partnership with key stakeholders internally and externally.

2. Deliver against Ministerial priorities as established in Departmental strategies and policies and translated into targets. In particular, the Chief Executive will be expected to deliver against all targets which are identified as critical and mandatory by the DoH and HSCB.

3. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and that human, physical, capital and financial resources are effectively deployed to meet those needs, in line with targets, and achieve the best outcomes possible.

4. Manage an effective process to ensure the continuing, objective and systematic evaluation of clinical and social care services offered by the Trust and ensure rapid and effective implementation of indicated improvements.

5. Lead the Trust in making an effective contribution to education, teaching and research.

6. Ensure that systems to provide high standards of care are based on good practice, research evidence, national standards and in accordance with guidelines, and to audit compliance to those standards and the statutory duty of care.

7. Achieve and sustain a high level of public confidence in the appropriateness, priority, safety and effectiveness of services provided by the Trust

8. Ensure that effective systems are in place to take learning from complaints and other actions against the Trust and translate these into action for improvement.

PATIENT/CLIENT CARE

10. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services. In so doing, ensure that a culture, which is fully consistent with the Trust vision and values, is embraced by every member of staff.

11. Ensure consistent application of the highest standards of clinical, social care and corporate governance.

STRATEGIC LEADERSHIP

12. Provide clear leadership for the Trust in the development of strategic plans, ensuring these are aligned with regional requirements and are effectively implemented through annual business plans.

13. Development of a common understanding of the vision and strategic aims of the Trust.

14. Provision of clear and positive leadership, motivation and development to all staff throughout the Trust to ensure their engagement with and commitment to achieving strategic change and delivering on the business plan.

15. Work with the Trust Board, staff and partners in the local health economy to ensure aligned delivery against strategic plans.

16. Work with other key strategic partners, both within and outside of the health and social care economy, to ensure key issues associated with health inequalities are addressed.

CORPORATE MANAGEMENT

17. With the Chair, be responsible for the organisational structure of the Trust, its probity and effectiveness.

18. Manage the Trust through the senior management team, ensuring and maintaining effective operational management processes.

19. Ensure that the work of the Trust is clearly and effectively communicated to employees throughout the organisation and that members of the Board are aware of issues and opinions of key staff groups.

20. Continually evaluate and review all services in order to deliver user centred treatment and care. Change systems and practices as necessary to improve services and establish a culture of continuous improvement and innovation.

21. Ensure that systems and processes are in place to enable the Trust Board and relevant external bodies to evaluate the effectiveness of the Trust's use of human, capital and financial resources and that people perform to the best of their ability and address under-performance quickly and effectively.

GOVERNANCE

22. Work with the Chair to ensure that the Board works effectively in fulfilling its role in ensuring the delivery of targets to deliver effective governance in accordance with public sector values and the relevant code of practice.

23. Work with the Chair and Trust Board to deliver effective governance in accordance with public sector values and the codes of operation and Accountability.

24. Work with the senior management team to ensure that assessment of fulfilment of statutory functions and associated reports to Trust Board and externally, are completed as necessary ensuring that any action to manage risks internally in the Trust is taken promptly.

25. Ensure that robust arrangements are in place to meet the statutory clinical and integrated governance requirements.

26. Ensure that arrangements are in place to assure all quality standards.

27. Monitor and report on performance against delivery targets, risk assessment and mitigation and ensure corrective action is taken when there is unacceptable deviation from the Trust's agreed business plan.

EXTERNAL RELATIONSHIPS

28. Establish collaborative relationships with external partners in the public, private and voluntary sectors to develop initiatives which will improve services and inter-agency communication.

29. Develop linkages with other Trusts, the HSCB, Public Health Agency (PHA) and the DoH to promote best practice and innovation in the provision of services.

30. Work with the DoH, the HSCB, the PHA and other Trusts in developing a strategy for dealing with the media which reflects Ministerial views and which secures the confidence of public representatives.

31. Develop a strategy to maximise effective engagement of the local population with the Trust and ensure that Public, Patient Involvement (PPI) and co-production is embedded in Trust processes.

32. Ensure effective on-going political engagement with public representatives including members of the UK Parliament, members of the Northern Ireland Assembly and elected representatives of the District Councils within the Trust's geography.

FINANCES

33. Work through the senior management team to ensure that budgets are managed appropriately and give the best outcomes for resources available.

34. Ensure that robust financial systems and controls are in place to achieve "break-even" on budgets and that immediate action is taken to control over-spends.

35. Develop, through the Finance and HR Directors, effective and relevant management information on financial spend and inter-linkages such as overtime, absence and agency costs, which inform management and control of budgets.

STAFF RESOURCES

36. Ensure that people management practices support continuous improvement in staff capability and quality of services provided including encouragement of and widening participation in learning opportunities.

37. Lead the development of systems to promote the health and well-being of staff.

38. Develop and maintain systems to support performance appraisal for all staff to ensure that staff are encouraged and developed to their fullest potential and that under performance is dealt with quickly and remedial action taken.

39. Develop, through the Director of Human Resources & Organisational Development, management information on staff utilisation, development and return on investment, which improve management and a rigorous continuous improvement culture.

40. Ensure that the Trust has a diverse and representative workforce, and that the right skills are in the right place to deliver its objectives.

DEVELOPMENT OF SELF

41. Lead by example to ensure that the Trust demonstrates respect, through its culture and actions, for all aspects of diversity in the population it serves and the staff who provide the services.

42. Lead by example in practicing the highest standards of conduct in accordance with the HSC Code of Conduct.

43. Continuously strive to develop self and improve capability in the leadership of the Trust and its staff.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

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

45. Maintain staff relationships and morale amongst staff.

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

47. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

GENERAL REQUIREMENTS

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

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

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

	January 2022.

Trust Endowments and Gifts Committee

Function	Provides assurance to the Board on all aspects of the stewardship and management of funds donated or bequeathed to the Trust.
Membership	• Chaired by Non-Executive Director • Two Non-Executive Directors • Operational Service Director (Acute) • Director of Human Resources and Organisational Development • In attendance: Director of Finance, Procurement and Estates and her staff
Frequency	Quarterly
Examples of Business	• Monitors the use and rationalisation of funds and advises on and approves expenditure requests from the Fund Managers • Reviews the final audited Trust Funds Accounts and Trustee's Report
Comments on operation and assurances	I am not a member of this committee, although clearly I have a considerable line of site into its actions give that it is discussed in detail at both SMT and Trust Board

Performance Committee

Function	Assists the Trust Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.
Membership	• Chaired by Non-Executive Director • Four Non-Executive Directors • In attendance: - Chief Executive - Executive Directors (Finance, Medical, Nursing & AHPs and Social Work – also Director of CYPS) - Director of Performance and Reform - Director of Human Resources and Organisational Development - Assistant Director of Performance Improvement
Frequency	***Quarterly***
Examples of Business	• Corporate Performance Scorecard • Performance Report highlighting broader operational performance issues/ risks • Integrated performance reporting including deep dive approach • Internal and external reports outlining the Trust's performance against a range of indicators.
Comments on operation and assurances	This is a committee that I introduced in October 2019 following detailed discussion with the Chair and other Trust Board members. I was concerned that the opportunity for detailed conversation and interrogation of Trust-wide performance was simply not available, due to time constraints, at the full Trust Board meeting. The creation of the performance committee has allowed a space for a detailed analysis of key performance indicators and to provide a check and challenge function. It

	• Quarterly Trust-wide Mortality Report • Annual Clinical Audit Report • Weekly SMT Clinical Governance Report • Litigation Annual Report These reports come to SMT for awareness and scrutiny. To strengthen this process further I have introduced, through the medical director, a new approach to governance reporting and assurance to me and SMT. When I first joined the Trust it was clear that operational clinical governance was very directorate specific. In other words, each of the directors had their own governance manager and governance team. These teams would rarely mix across the Trust and reporting and monitoring was from within existing directorates, arguably silos. Now, with the weekly governance meetings, bringing together all governance teams from across all directorates, and creating one weekly governance report to the senior team, we are able to assess every week how the system is working. This allows us to check, challenge and make changes.

Q23	**Please provide examples of a number of issues that have been escalated through to the Trust Board or Trust Board Committees where there have been patient quality and safety concerns. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Do you as CEO have any concerns about these processes and are you making any changes which will improve assurance and ownership at all levels in the Trust?**
Response	I have outlined below, with direct extracts from Trust Board minutes, three examples of how Trust Board has operated during my tenure with regards to issues being raised. I have also attached all appropriate documents as appendix 45 to support the full example. Issue 1 – Whistleblowing in Obstetrics and Gynaecology – Summary The background to this issue was that we had received a whistleblowing allegation from within the service which alleged poor quality of care in delivery suites. At the same time, through the governance committee, it had been noted that a number of the current litigation matters were from the Obstetric and Gynae areas. This resulted in information on safety and performance being presented to the Governance Committee, an independent whistleblowing investigation being carried out and the development and implementation of an improvement plan. Issue 2 – Mental Health Services – Summary The background to this issue is that an alleged assault on a patient was reported in March 2018. This incident was reviewed by the local team and was escalated. This was the trigger for a more in-depth review of the Dorsy ward and then onwards to an independent review of the whole unit (Bluestone). The notes below track the identification of issues, the action taken, the interaction with the Trust Board and the implementation of improvements. Issue 3 – Dr A - Summary In this situation Dr A raised concerns that adverse incidents were not being categorised correctly and that staff were downgrading the seriousness of them. The notes below highlight how it was identified and addressed to an agreed conclusion. In all situations the process allowed for issues to be raised, for Trust Board to challenge and for action to be taken. I believe that the three examples reveal clear engagement, challenge, planning and

governance arrangements within the Medical Directorate and the wider organisation. The output of this review was a series of recommendations for implementation by the Trust.

There were a total of 48 recommendations made which were broadly categorised under the following themes;

- Corporate Good Governance (Trust Board including Board Committees and Sub-Committees;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Governance Information Systems including Datix;
- Clinical and Social Care Good Governance Structures.

These recommendations became the basis of our Clinical and Social Care Governance (CSCG) change journey.

How do you ensure that the Board is appraised of both serious concerns as well of current performance against applicable standards of clinical care and safety?

As Chief Executive I ensure Trust Board is appraised of both serious concerns and current performance against applicable standards of clinical safety via the following mechanisms:

- Non-Executive Director briefings conducted by myself (monthly currently, previously were weekly during pandemic period)
- Trust Governance Committee - As above, Governance Committee also allows for issues of serious concerns / performance issues that are identified to be raised and discussed directly with Governance Committee members
- Trust Board Meetings – Trust Board meetings hold a 'confidential' session at the beginning of each meeting that is closed to the public allowing for sharing of information on concerns / performance issues that are identified to be raised and discussed directly with Trust Board members. These confidential meetings are minuted to ensure an accurate record but they are not held in public session so that issues of policy in development or confidential in terms of identifiable information can be shared

What is your view of the efficacy of these systems?

As reference above, in 2019, I commissioned the HSC Leadership Centre to review the complete governance system within the Trust. I was concerned that the system was disjointed and that from my experience the system was not operating as I had experienced in other HSC organisations. I had a number of concerns based on my experiences;

1. The level of expenditure on the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines.
2. There was little evidence of a systematic and dynamic flow of clinical and social care information to SMT on a regular basis. Clearly if there was an issue of concern there was evidence of items being raised. However my concern was that this was based on a 'push' system from the directorates, not from a regular systematic review process.
3. The level of data and statistical evidence being brought to the SMT, in respect of quality and safety, was lower that what I was used to in other organisations.

	On the basis of this, I approached the Chief Executive and asked for support in commissioning a review of CSCG across the Trust. This was undertaken through the Leadership Centre by Mrs June Champion who is a highly regarded local expert in this area. She produced the Champion Report in September 2019.
Did you have concerns about the governance arrangements and did you raise those concerns with anyone?	Yes, I had concerns about the paucity of the functions usually associated with providing a robust system of governance. I brought this to the attention of the Chief Executive, Mr Shane Devlin, who supported the commissioning of Mrs June Champion to produce the Champion Report in September 2019. In addition to this, to strengthen governance assurance in the operational directorates I introduced and led the weekly Trustwide Governance Group which includes Clinical Executive Directors and Divisional Medical Directors, which reports weekly to SMT and monthly to Trust Non- executive Directors ATTACHMENTS: CHAMPION REPORT, RESPONSE, UPDATED ACTION PLAN. Documents located at S21 No 29 of 2022, *53. CHAMPION GOVERNANCE REVIEW 2019, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS* I also had concerns about Professional Governance in the ST and this was strengthened to address these concerns.
If yes, what were those concerns and with whom did you raise them and what, if	The concerns were that the Clinical and Social Governance systems, specifically management of complaints ,SAI, standards and guidelines, clinical audit and Datix, mortality reporting and the quality assurance of these systems and triangulation of these systems were not well enough developed to provide enough governance assurance. This was raised with Mr Devlin, SMT and Trust Board and plans and funding strategies were agreed through a programme of improvement. The first aspect of this was to develop plans for improving Standards and Guidelines, Datix and SAI in year one and mortality reporting was brought up to date. Through the relevant strategies these have been progressed following significant investment.

Executive Summary

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

During the course of the Review senior stakeholders provided the context to the development of integrated governance arrangements from the Trust's inception in April 2007 and from recommendations arising from an internal Clinical and Social Care Governance Review undertaken during 2010 and implemented in 2013 and a subsequent revisit of the 2010 Review in April 2015. Senior stakeholders identified that there had been many changes within Trust Board and the senior management team over a number of years which had had a destabilising impact upon the organisation. They cited the number of individuals who had held the Accountable Officer/Chief Executive in Interim and Acting roles as having the most significant impact and welcomed the appointment of the Chief Executive in March 2018. It was also noted that the role of Medical Director had also been in a period of flux since 2011.

The Report provides analysis (and recommendations) throughout Section 4 on what constitutes a good governance structure. Good governance is based on robust systems and processes by which the organisation directs and controls their functions in order to achieve organisational objectives. As a legal entity the Trust has in place the required elements of a good governance framework; Standing Orders, Standing Financial Instructions and a Scheme of Delegation. There is a well-defined high level Board governance structure (Board Committees Section 4.1.3) and terms of reference. The Trust Board sub-committee structure is less well defined and requires revision (Section 4.1.9). Senior stakeholders identified a lack of connectivity across the existing Governance Structure and a lack of a robust assurance and accountability framework which added to the perception that the core elements of integrated governance were being delivered in silos with various reporting lines (corporate, directorate, professional and expert/advisory committee). The proposed revised good governance structure will provide the Trust with an assurance and accountability framework which will also address the concerns expressed in respect of existing accountability/ reporting lines to Trust Board.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance. The revised assurance and accountability framework will improve connectivity by bringing together the full range of corporate,

clinical, social care, information and research governance activities into an integrated governance assurance and accountability framework through a single point of first level assurance, the Senior Management Team, to Trust Board.

There were many areas of good practice outlined during interviews with senior stakeholders; leadership walk rounds conducted by members of Trust Board, a Controls Assurance Group to continue to focus on maintaining sound systems of internal control and patient and service user initiatives including a lessons learned video on patient engagement with a mother who was involved in a Serious Adverse Incident Review following the death of her child. The video has been shared as an example of best practice by the Department of Health Inquiry into Hyponatremia-related Deaths Implementation programme at stakeholder events.

The core elements that underpin a good governance framework, strategic and operational systems of internal control and processes, were evaluated against best practice guidance (Sections 4.2-4.23). They were also evaluated for clarity of accountability, roles and responsibilities. The analysis demonstrated that many of the building blocks for good governance are in place e.g. a Board Assurance Framework, Corporate Risk Register, Risk Management Strategy and operational policies e.g. adverse incident reporting, health and safety management, claims and complaints management. However, gaps in controls and assurances in these systems and processes have been identified and recommendations made. A number of the policies and procedures are dated and require revision and updating with extant guidance. There is variation from Directorate to Directorate the application of operational policies e.g. management of complaints. Senior stakeholders identified examples of best practice in some areas, as identified above, which have not necessarily been shared or applied across the organisation. There have been changes in the roles and responsibilities at Executive Director level and these will need to be defined in revised strategy and policy documents, this will clarify the lines of assurance and accountability which will underpin the Framework as above.

Stakeholders identified lack of resources (staff and information management systems) in integrated governance structures at both a corporate and directorate level. They also identified the ever increasing demand on the existing resource for example in the management of serious adverse incidents and complaints, clinical standards and guidelines and implementation of the Regional Morbidity and Mortality System. Analysis and recommendations have been made throughout Section 4. The Corporate Clinical & Social Care Governance structure has been benchmarked against a peer Trust corporate team who provide a similar function and support an assurance and accountability framework as above (Section 4.23).

In considering recommendations for the Trust the Reviewer took account of the Inquiry into Hyponatraemia-related Deaths (IHRD) Report and Recommendations and the ongoing work of the IHRD Implementation Group and Department of Health (DoH) Workstreams.

The Trust may wish to consider constituting a task and finish/director's oversight group to oversee the implementation of the action plan to implement the findings of this Review.

There are a total of 48 recommendations contained within Section 4 which are broadly categorised under the following themes;

- Corporate Good Governance (Trust Board including Board Committees and Sub-Committees;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Governance Information Systems including Datix;
- Clinical and Social Care Good Governance Structures.

A summary of the Recommendations is provided in Appendix 1. The summary of Recommendations should be considered in line with the related analysis and narrative in Section 4.

Summary of Recommendations **Appendix 1**

Theme/ Rec No	Recommendation	Timescale[40]
Good Governance Structures – Board Governance		
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020. .	M
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	M
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	S
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	S
5	The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers.	M
6	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy.	M
7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	S-M
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	M
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	S

[40] Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

Theme/ Rec No	Recommendation	Timescale[40]
	the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1.	
Morbidity & Mortality – link with Medical Leadership below		
41	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	S
42	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below).	M
Shared Learning for Improvement		
43	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	S-M
Governance Information Management Systems (Datix)		
44	1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations. 2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	M
Corporate Clinical and Social Care Governance Structures		
45	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT.	S
46	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	M
Corporate & Directorate CSCG Interface		

The Chair stated that mindful of the Board Behaviours that all members subscribe to, and in the spirit of openness and honesty, as Chair of the Trust Board, she felt very offended by the report in how it was written in relation to Trust Board. For example, she was named as a contributor, when, in fact, had not been involved and only met the author at the final draft stage. Whilst she agreed with the Chief Executive that he can undertake a review at any time, she understood that it was a review specific to clinical and social care governance, yet it went wider than its terms of reference and strayed into corporate governance which she felt should have involved herself and the Non-Executive Directors. She made the point that Trust Board has a responsibility to ensure that the Trust has effective systems in place for governance; therefore it was important for Trust Board to have discussion on the report and agree a way forward.

Discussion on the report ensued in which some Non-Executive Directors expressed their concerns about how the review was conducted with no involvement of the Non-Executive Directors until the draft report was already written, the quality of the report and its current status. Mrs Magwood also raised the fact that the review included quality improvement and information governance and, as Lead Director for both areas, she was not effectively informed nor involved. Mrs Toal highlighted the importance of the final report accurately reflecting the Terms of Reference that were developed. The Chair responded that the focus of the Terms of Reference was on clinical and social care governance. The Terms of Reference were subsequently circulated to Non-Executive Directors following the meeting by way of reminder. Both the Chief Executive and the Medical Director apologised if there were any misunderstandings in the report or in the process that was used.

The importance of the Chief Executive using the Trust's finite resources well in terms of time, money and people in addressing some of the recommendations was highlighted. A reviewer from outside Northern Ireland as opposed to the Leadership Centre was also suggested.

Following discussion, it was suggested that Non-Executive Directors would forward any inaccuracies they felt required to be corrected, to the Chair's office. The Chief Executive agreed that he would then meet with the author of the report to ensure that the

Chair informed members that due to the current coronavirus situation the workshop requires to be scaled back to allow the Senior Management Team to attend an urgent meeting, therefore item 8 Strategic Planning will be deferred and the workshop will end at 12.30 p.m.

2i. NOTES OF PREVIOUS WORKSHOP HELD ON 17th OCTOBER 2019

The notes of the previous meeting were agreed as an accurate record and approved by members.

2ii. NOTES OF BOARD DEVELOPMENT DAY HELD ON 14TH NOVEMBER 2019

The notes of the Board Development Day were agreed as an accurate record and approved by members.

3. MATTERS ARISING

Members noted the progress updates from the relevant Directors to issues raised at the previous workshop.

4. CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW

At the outset, the Chief Executive advised that he had been reflecting on section 4 of the final draft report (November 2019) on what constitutes a good governance structure and acknowledged that the wording in 4.1.9 in relation to sub committees was confusing and misleading and would be corrected. He confirmed that the report was a review of governance structures below Trust Board sub-committee level and he did not expect the structure above that level to change.

The Chief Executive stated that the purpose of the report was to provide learning as to how the Senior Management Team could better support Trust Board and he welcomed the recommendations and key actions in the report relating to this. He highlighted the importance of the diagram in Appendix 2 '*Governance Committee and Sub Committee Structures underpinned by Directorate Accountability Arrangements'* which sets out how the organisation would be structured to support Trust Board.

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Notes of a Directors' Workshop held on Thursday, 27th February 2020 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Acute Services
Mr B McNeany, Director of Mental Health and Learning Disability
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Notes)*

1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies were recorded from Mrs E Gishkori, Director of Acute Services. The

Southern Health and Social Care Trust

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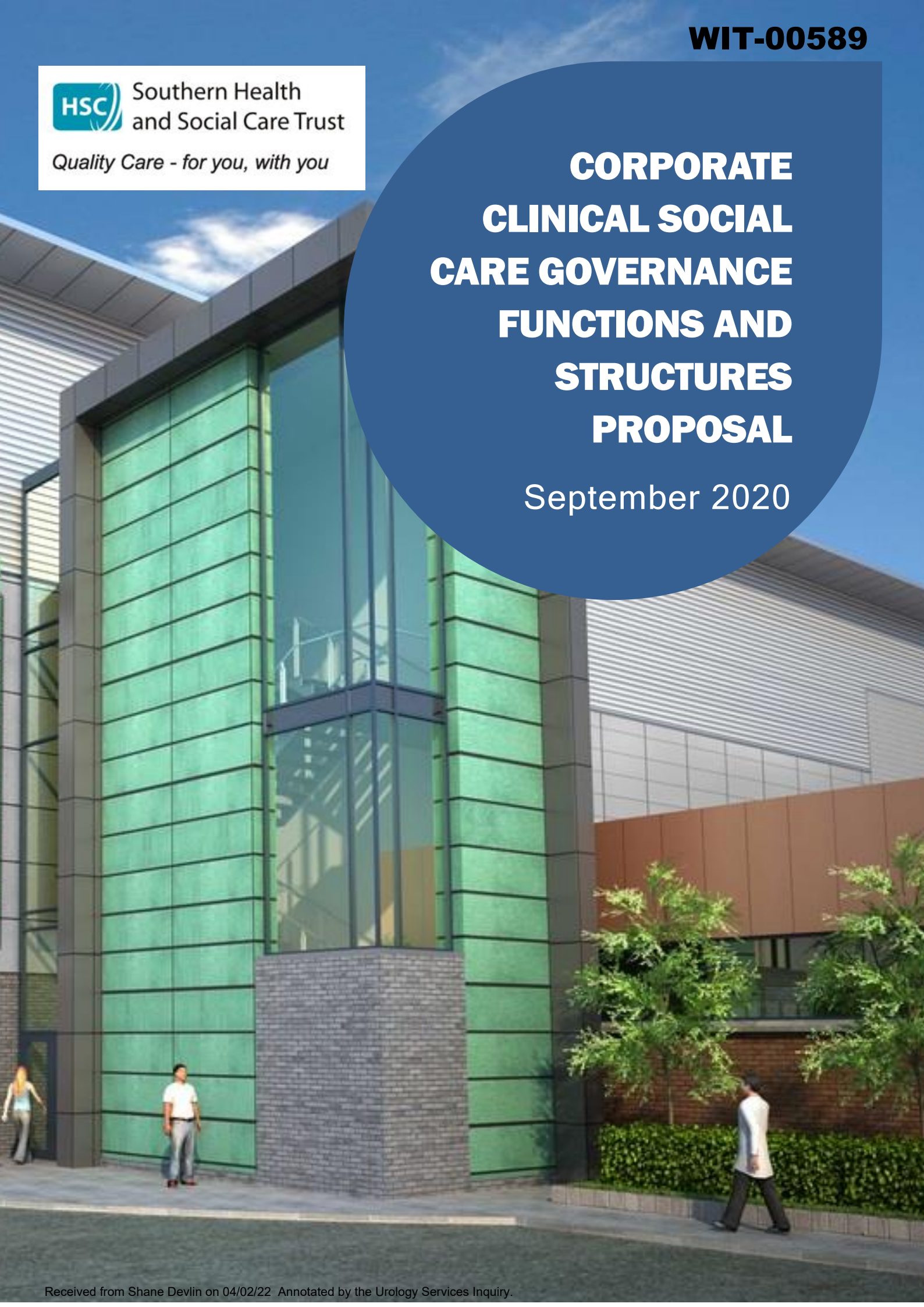
CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

September 2020



PROPOSAL 1 – REALIGNMENT CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURES

18. The Trust has traditionally operated a model of distributed clinical and social care governance. The Medical Director serves as the overall Director with responsibility for the function. The model has the following key characteristics:

- Each Operational Directorate has a senior Governance Coordinator post which reports directly to the service director
- Each Operational Directorate retains responsibility for the approval and final sign off of all clinical and social care governance activity relating to their service areas
- Each Operational Directorate decides at a local level the funding and resourcing requirements for their clinical and social care governance service areas.
- Each Operational Directorate is responsible for designing systems and processes for delivering on their clinical and social care governance function (for example staff designing and delivering, training, adverse incident and serious adverse incident screening and completion, complaint management processes, management and oversight and standard and guideline implementation etc)

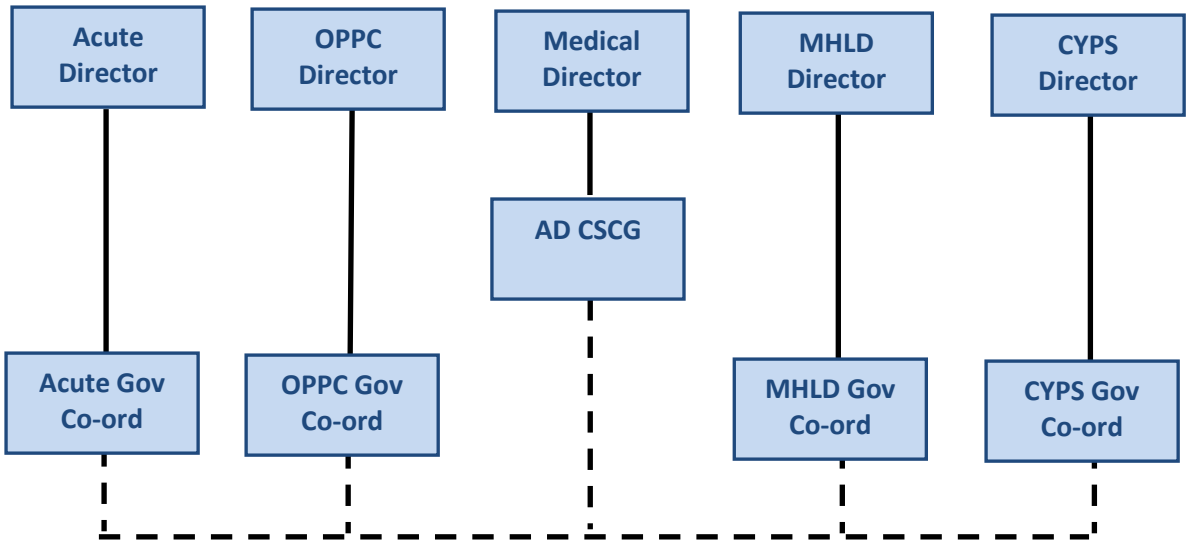


Figure 1 – Current Clinical and Social Care Governance Structure within the Trust

Challenges with a distributed Clinical and Social Care Governance Structure

19. The following weaknesses have been identified in the current distributed structure:

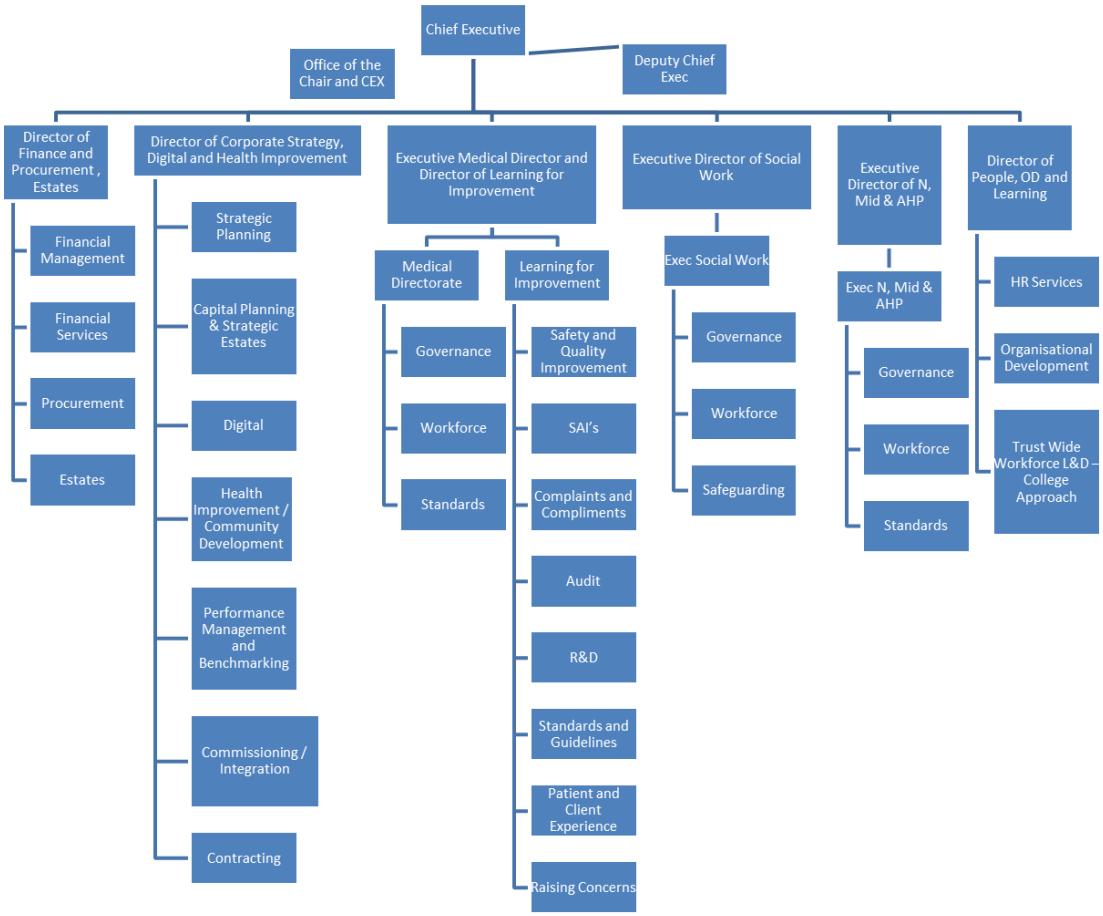
- Corporate quality assurance of Clinical and Social Care Governance processes and outputs

- Local management of resources does not allow for cross cover of functions across directorates when the need arises
- Variable understanding of the elements of Clinical and Social Care Governance
- Variable understanding of the elements of learning and improvement
- Processes are non-standard across service areas including:
    i. Screening processes for SAI identification
    ii. Processes governing the conducting of SAI reviews
    iii. Monitoring of Learning and assurance of implementation
    iv. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
    v. Processes governing the identification and implementation of Standard and Guideline processes
    vi. Provision of localised training at directorate level
    vii. Processes for managing and responding to complaints
- Gaps in service provision have been identified by BSO internal audit findings including Risk Management, Management of Incidents and Morbidity and Mortality which correctional improvement actions are hindered by non-standardised processes.

20. The lack of standardisation of systems and processes across directorate teams inhibits the ability for clear corporate quality assurance and oversight.

Potential Benefits of a Corporate Business Partner Model for Clinical and Social Care Governance

21. The benefits of a corporate lead service include:
    - Corporate overall oversight of all Clinical and Social Care Governance Processes including SAIs, Complaints, Adverse Incidents, Morbidity and Mortality.
    - Allowing 'depth' of governance function to ensure that staffing levels remain consummate with task requirements
    - A standardised focus on the elements of Clinical and Social Care Governance
    - A standardised focus on the elements of learning and improvement
    - Standardisation of processes across service areas including (as above):
        i. Screening processes for SAI identification
        ii. Processes governing the conducting of SAI reviews



At the heart of the structure is a new directorate of 'Learning for Improvement'. It will become the central hub for bringing together all information sources that support quality and safety improvement. It will become the key conduit, through the Medical Director, for Clinical and Social Care Governance through to the Governance Committee of the Trust Board. The other major change in the structure from a governance perspective is the introduction of a stand-alone Executive Director of Social Work. This will bring the social work executive director in line with Medicine and Nursing. In the current structure the Exec Director of Social Work also carries a considerable operational portfolio, hence this move will allow for a greater focus on professional and governance issues.

From an operational delivery perspective it is proposed to create directorates.

- Unplanned Urgent Services
- Elective and Cancer
- Women's and Children's Health
- Children's Community Services
- Older Persons Community Services
- Mental Health and Disability

Q8	**Describe how you usually engage with your Senior Management Team on a day-to-day basis, including the Medical Director.**
Response	My engagements with my senior team on a day to day basis takes the following format:

- Local management of resources does not allow for cross cover of functions across directorates when the need arises
- Variable understanding of the elements of Clinical and Social Care Governance
- Variable understanding of the elements of learning and improvement
- Processes are non-standard across service areas including:
    i. Screening processes for SAI identification
    ii. Processes governing the conducting of SAI reviews
    iii. Monitoring of Learning and assurance of implementation
    iv. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
    v. Processes governing the identification and implementation of Standard and Guideline processes
    vi. Provision of localised training at directorate level
    vii. Processes for managing and responding to complaints
- Gaps in service provision have been identified by BSO internal audit findings including Risk Management, Management of Incidents and Morbidity and Mortality which correctional improvement actions are hindered by non-standardised processes.

20. The lack of standardisation of systems and processes across directorate teams inhibits the ability for clear corporate quality assurance and oversight.

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    - Allowing 'depth' of governance function to ensure that staffing levels remain consummate with task requirements
    - A standardised focus on the elements of Clinical and Social Care Governance
    - A standardised focus on the elements of learning and improvement
    - Standardisation of processes across service areas including (as above):
        i. Screening processes for SAI identification
        ii. Processes governing the conducting of SAI reviews

iii. Monitoring of Learning and assurance of implementation
iv. Triangulation of Data to inform Improvement Plans and Learning
v. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
vi. Processes governing the identification and implementation of Standard and Guideline processes
vii. Provision of Trust-wide standardised staff training
viii. Processes for managing and responding to complaints

22. The structure detailed below illustrates how the accountabilities would move.

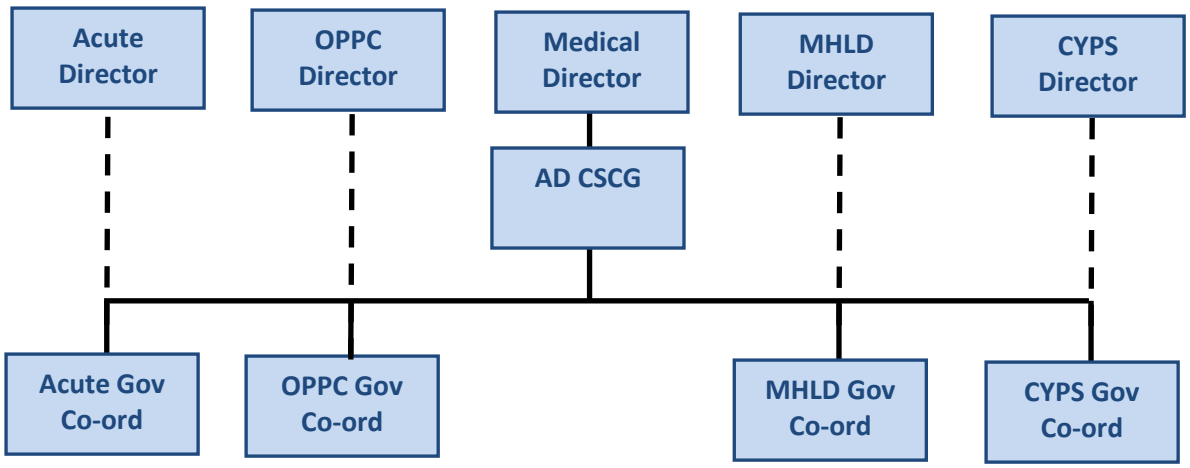

Figure 2 – Proposed Clinical and Social Care Governance Structure

23. This proposal advocates the development of a Corporate lead clinical and social care governance structure with operational management transferring to the Medical Directorate.

24. Operational directors will retain responsibly for the commissioning and oversight of clinical and social care governance activity in the same model as is delivered by other corporate services such as Finance and Procurement, Human Resources and Organisational Development and Performance and Reform.

Options Appraisal

Option 1 – Do Nothing – Existing Directorate Led Model Remains in Place

The current system continues without the ability for robust corporate clinical and social care governance oversight. Risks continue to exist regarding resourcing for directorate level clinical and social care governance team resourcing. Standardisation of processes will

Continuing Issues

1. Paediatric Surgery

New Paediatric Units at DHH and CAH supposed to have come on-line in January. Two problems have emerged.

a. We have not secured additional medical staff to provide 24 hour cover at DHH and surgical colleagues will not, therefore, undertake any work that may require an inpatient stay. They will only do this work at CAH.

b. Surgical colleagues advise that the bed numbers did not take account of the full range of activity and are not sufficient.

Initially colleagues were reluctant to do any elective work before these issues are resolved. A number of meetings have taken place and the Medical team have offered (on a short term basis) to give up 2 beds in the CAH Unit (giving surgery 5 beds in total). Aldrina is looking at the activity in order to determine how many additional beds might be required in the CAH unit to provide for the activity that is not now going to DHH (until the cover is secured) and the surgical activity apparently not provided for in the plan.

Staff involved include Ahmed Khan (Paediatrics), Mark Haynes (Surgery), Personal Information redacted by the USI and Aldrina Magwood.

2. Hyponatraemia

Following the publication of the report, the Trust met Personal Information redacted by the USI's mother and grandmother. They left 6 questions (answers now available). The family said that what they wanted most was a face to face meeting and an apology from the two doctors most involved in Personal Information's care. One colleague has agreed to a meeting and this is to be in April.

Staff involved include Irrelevant information redacted by the USI and Irrelevant information redacted by the USI.

3. Mr and Mrs Cawdrey Murder (May 2016)

Mr and Mrs Cawdrey's family (represented by Irrelevant information redacted by the USI) have ask Irrelevant information redacted by the USI from the charity 'Irrelevant information redacted by the USI' to act on their behalf in obtaining answers to a number of questions concerning the Trust's involvement with the person charged with the murders. To date the Trust has said that the duty of confidentiality to the patient constrains it from providing the information requested. Following the Hyponatraemia report and the recommendations on openness DLS advised that it would be appropriate to advise that the Trust would pass the questions to the Chair of the investigation team. The family have been asked to confirm the list of questions. Irrelevant information redacted by the USI and Irrelevant information redacted by the USI have stressed the importance to the family that the answers are provided in advance of the information becoming public knowledge. The Trust is currently exploring the process in order to see if this is possible.

Staff involved include Dr Chada, [redacted], Jane McKimm.

4. [redacted] (retired)

[redacted] passed on two allegations:

- that the Trust offered locum staff more to cover shifts at CAH than it did for DHH

- that the Trust downgraded the severity rating given by clinical staff to SAIs.

The Trust asked the leadership centre to undertake an investigation. The subsequent report advised that no evidence to support these allegations had been provided by any of the staff interviewed. In a subsequent meeting [redacted] advised that the pay rate allegation was passed to him by a member of the public and he was content to let that matter rest. He remained concerned about the DATIX issue. In order to resolve the matter and in line with the response to the findings provided by Dr Wright (shared with Governance Committee) [redacted] was invited to nominate three colleagues to sit on a review group to fully investigate any SAI that he or others were concerned about along with a sample of other incidents. Unfortunately, [redacted] is ill and his nominations have not yet been received.

Staff involved include Dr Wright, Vivienne Toal, Jane Mc Kimm.

5. Elective Cancellations

The Trust advised the HSCB/DOH that it would formalise the policy and procedure for the cancellation of red flag and urgent elective activity during periods of immense bed pressure. A paper has been approved by SMT and Trust Board requires an update on 29th.

Staff involved, SMT.

6. Maternal Death DHH - Internal reporting procedure.

7. Child Death in ROI, child born in CAH.

8. Medical/ Nursing revalidation.

9. Duality, Private GP practice, letter to HSCB re interface with SHSCT (they follow normal GP process, we provide services at same cost basis as any other GP as long as they undertake not to charge for any service provided to them free of charge).

Q54	**Please describe all issues of concern arising out of Urology Services within the Trust which came to your attention and what assurances you sought regarding those concerns.**
Response	A summary of the concerns raised and the assurance sought are below. On the 6th September 2018 Dr Khan, acting Medical Director, made me aware that in his role as case officer for the Managing High Professional Standards case of Mr A O'Brien he was engaging with the GMC and the Trust HR function to start disciplinary procedures. (Reports included as appendix 18a and 18b) I had been made aware of this case by Vivienne Toal, Director or HR, in the previous months including that she had considerable concerns about the performance Mr O'Brien. At that time I had asked Vivienne for further information and I was advised of the incidents of 2016/17 whereby 783 untriaged letters were discovered in a drawer in Mr O'Brien's office as well as 307 sets of patient notes at his home address. In addition, a further 668 letters had no dictation outcomes and there were queries as to whether the management of private patients was in line with the agreed Trust processes. When the matter was raised to me in September 2018, I asked for an assurance from Esther Gishkori, then Director of Acute Services, and Dr Khan that the issues that had been identified two years previously (i.e., in 2016/17) had been addressed. I was advised that an SAI was being carried out to fully understand the learning, however in the interim control measures had been put in place. This involved monitoring by the service lead, Martina Corrigan, and the Assistant Director for Surgery, Ronan Carroll. This involved weekly monitoring of agreed actions. Following these conversations, I was assured that the existing issues were being dealt with. In the middle of June 2020 (I do not have a note in the diary of the exact date), Maria O'Kane, Medical Director, approached me in my office to raise her serious concerns about an issue that had come to her attention. She had been made aware by Mark Haynes, Associate Medical Director (Surgery), that an e-mail had been sent from Mr O'Brien to request that his patients that had not been added to the waiting list were to be considered for an urgent bookable list. When the Mr Haynes reviewed this further it was clear that there were other patients that required to be investigated. At that point Dr O'Kane had already commenced an administrative review and suggested that the offer for Mr O'Brien to return to work following his retirement should be withdrawn. I supported this proposal. Dr O'Kane and Melanie McClements (Director of Acute Services) then set about developing system and processes to review the situation and to develop a plan. Dr O'Kane and Melanie McClements continually updated me on the situation as it developed and as we developed new structures. With regards to my role I was not directly involved in the lookback exercises at that stage although I did receive regular updates from the team. The formal update was then presented to the Urology Assurance Group, UAG, chaired by the Permanent Secretary. I have attached the terms of reference for the UAG as appendix 45. To ensure that we were able to safely manage and improve moving forward I introduced a new project governance structure. I appointed Heather Trouton, Director of Nursing, as the Director responsible for the Urology Inquiry. We established three workstreams. 1. Inquiry Management, 2. Lookback Management and 3. Improvement. This structure provided a controlled framework to ensure that all three arms of the work required could be successfully managed. All three workstreams report into me as the CEX. These structures are described in appendix 49c

Complaints

Q55	**Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of**

Southern Health and Social Care Trust

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

meeting re AOB.

GMC.
- waiting lists. Patient Safety Conc + when he raised this.
- letters / emails concerns re patient safety concerns.
- AOB did not appear to raise specific concerns.
- He did not provide concrete evidence.

- organisational part discussed
- meeting c Shane. → after rep Vivienne / Shane.
- Systems dip.
- Elbuler wasn't @ meeting.
- System + under load work. minuted
→ not addressed.
- NED agreed
- Trust position
- Feedback on his feedback to casemanager.

Head of Service.
- management action plan.
- Feb 2017 Mx action plan.
→ (N) line management + to escalate to case manager by exception to Dr Khan.
→ expectation that usual line management will report by exception
→ are we confident that this is robust?
→ Shane + Vivienne.
→ I will email. Esther re assurance that.
→ how are charts travelling. Did we ever get assurance from him that not doing pp from home? [triage]. minute from Joanne not to practice from home. Ahmed advised him to desist from pp @ home. Never received written assur

→ Appeared good sense re ppl
→ clarification re private patient BN.
→ (RO)

6th June 2018. Joanne Donnelly
2nd Oct 2018.
Oct 2017.

pr → mother undertaken for his own home. Clarification.

- No formal concerns re W/L.
- ask Joanne formally to identify action
- Siobhan - grievance request.
→ I will talk to Joanne re organisational part.

- Agreed job plan. (*)
→

* Policy update *
Rv (1/12) 30th May. 10-12
12-12.30

2. Given that I was appointed to the Southern HSC Trust ('the Trust') in March 2018, and that the MHPS process for Mr O'Brien relating to sub-paragraph (e) of the Terms of Reference, began in very late 2016 / early 2017, my knowledge and involvement is limited, and is confined only to my period of employment.

3. The first that I was involved in the MHPS process with regards to Mr O'Brien was on the 6th September 2018, when Dr Khan, acting Medical Director, made me aware that, in his role as Case Manager for the case of Mr O'Brien, he was engaging with the GMC and the Trust HR function to start disciplinary procedures.

4. I had been made aware of this case by Vivienne Toal, Director or HR, in the months previous and that she had considerable concerns about the performance Mr O'Brien. I asked Vivienne for further information and I was advised of the incidents of 2016/17 whereby 783 untriaged referrals were discovered in Mr O'Brien's office as well as 307 sets of patient notes at his home address. In addition, a further 668 patients had no outcomes from clinics dictated and there was an issue in respect of Mr O'Brien's scheduling of his private patients.

5. When the matter was raised to me in September 2018 by Dr Khan, I asked for an assurance from Esther Gishkori, Director of Acute Services, and Dr Khan that the issues that had been identified two years previous had been addressed. I was advised that an SAI was being carried out to fully understand the learning however, in the interim, control measures had been put in place. This involved monitoring by the service lead, Martina Corrigan, and the Assistant Director for Surgery, Ronan Carroll, which involved weekly monitoring of the agreed actions. Following these conversations, I was assured that the existing issues were being dealt with.

6. My next and last involvement with the case was on the 27th November 2018, when Mr O'Brien asked to speak with me as he wished to submit a grievance against the Trust with regards to his treatment through the MHPS process. I met with him and received his grievance with accompanying supporting information. I passed both the grievance and information to Vivienne Toal, Director of HR.

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not.

63.1

Nature of Concern	***Raised With and When***	***Actions Taken***	***Outcome***
Mr O'Brien deviated from the 2017 action plan formulated following MHPS investigation (as referred to in my answer to Q54)	• MHPS Case Manager (16.09.2019) • NHS Resolutions • Directors' Oversight Group • Chief Executive • Oversight Group • GMC • Trust Board	Dr Khan Case Manager discussed with those involved including Mr O'Brien, Dr Grainne Lynn NCAS and the GMC on 24.09.2019 who asked for update by 07.10.19 This was discussed at an oversight group on the 03.10.19 and updated by Mr Haynes by email on 07.10.19. This in turn was discussed with the Chief Executive at 1-1 meetings and at Trust Board Confidential Sections as outlined in answer to question 40.	Before my tenure, a decision was made that monitoring using the MHPS Action Plan would continue with recognised additional time for Mr O'Brien to complete triage following his Surgeon of the Week. It was understood that he had deviated from the plan following the email of the 16th September 2019 time because his mother in law was unwell and required attention in hospital.
Patients found to not have been added to lists for required surgery 07.06.2020	• Trust Board • HSCB / SPPG • Directors' Oversight Group for Doctors in Difficulty	When this was discovered a review of Mr O'Brien's clinical work was immediately commenced by Mrs Corrigan to determine the extent of this problem. Ongoing discussions were	The developing awareness of the issues discovered as a result of the email of the 7th June 2020 and summarised in my

Trust Performance Committee

Name	Roles and Responsibilities	Tenure
Shane Devlin	Chief Executive	*October 2019 – present*
Dr Maria O'Kane	Medical Director	*October 2019 – present*
Colm McCafferty	Interim Director CYPS	*September 2021 – present*
	Exec Director Social Work	*September 2021 – present*
Heather Trouton	Exec Director of Nursing	*October 2019 – present*
Catherine Teggart	Director Finance, Procurement and Estates	*December 2021 – present*
Aldrina Magwood	Director Performance and Reform	*October 2019 – present*
Vivienne Toal	Director Human Resources and Organisational Development	*October 2019 – present*
Lesley Leeman	Assistant Director of Performance Improvement	*October 2019 – present*
Pauline Leeson	Non-Executive Director	*October 2019 – present*
Geraldine Donaghy	Non-Executive Director	*October 2019 – present*
John Wilkinson	Non-Executive Director	*September 2020 – present*
Hilary McCartan	Non-Executive Director	*May 2021 – present*
Martin McDonald	Non-Executive Director	*May 2021 – present*

Q6	**If the management structure detailed in the preceding paragraph has changed during your time in post, please set out when the changes occurred, what they were and the reason(s) for same.**
Response	There has been very little structural change in my time in post. The only major structural change was the introduction of the Performance Committee in October 2019 There have been a number of personnel changes within the existing structure.

Personnel Changes

Name	Title	Committee Memberships	Reasons
Roberta Brownlee	Trust Board Chair	Remuneration (Chair), Patient & Client Experience, Performance	Tenure Completion Date November 2020
Esther Gishkori	Director of Acute Services	SMT, Governance, Endowments & Gifts, Patient &	Resignation Date April 2020. This was a negotiated settlement. The Trust raised

3rd June 2019 pm

Esther, Shane and Vivienne

CX's office, Trust HQ

Shane - conscious of the uncertainty, had been exploring options over last number of weeks given position with Acute.

Conscious that there hasn't been growth in use of acute services compared with last year, but performance is falling. Many factors worried about – financially directorate was spending more than ever, locums increasing, daisy hill consultants and their letter of concern a number of months ago about the Directorate in January 19, and recent conversations with CAH consultants. All indicating that the directorate is not in the healthiest of positions, and clinicians are not engaged. I do want to make changes.

Esther – directorate is too big. Heather - taken away. Directorate is a 'beast'

Shane – I need to explore what we need to do. Need to create some space to think about how we achieve a clinically led directorate. I agree it is an enormous directorate.

I had thought that the patient experience role would be a productive opportunity and would give the space to see what stage the directorate needed to look like.

Also talked about a swap – Melanie and you

We haven't discussed – split of the directorate – break it up. Site based or unscheduled / surgery etc

Esther - I need to do something. Locum spending - inevitable given workforce

I'm going on sick leave – 6 weeks

Shane – what can be done – conscious you are going on sick leave. Can't do anything when you are off.

Esther – things will continue to get worse. I did try to save half million.

You want to do something.

Shane – I want to find a place for you in the process.

Esther – You want me out, plain as the nose on your face.

Chair got involved in all of this saying 'you'd be mad not to take this' – patient experience role

I said to her to step back.

It looks to me… no you continue

Shane – Chair is hyperactive in this space

24th July 2019 am

Shane, Esther, Vivienne

CX's office, Trust HQ

Esther – time to reflect being off. Job has been too big for me. I don't want to be somewhere else.

I know I'm not perfect, but if I can't be let make a go of this, then there needs to be a package to walk away.

My opinion on how it would be split. 2 Directors. You've talked Shane about someone above, I wouldn't want to be there in that role, I've told you that.

Split by 2 hospitals – not easy to do.

So split by medicine and unscheduled care and surgery / atics

Surgery one DHH base, Medicine / USC one – CAH base

Shane – Melanie has been covering for 5 -6 weeks now, she has given me her opinion too.

It's vital that whatever we do – management resource needs to look after money, performance and engagement.

I've looked at structures - come up with up to 8 possible models.

Split directorate – management survival. Site split is not an option, similar to you on that.

Cannot underestimate change required – radical change needed. I do think it needs a COO / Deputy CX. So some kind of model – COO with 2 splits, but maybe 2 directors, reporting to me maybe at the outset.

Esther – SMT full of hot air – not people in the room needed going forward.

I could transition into one of those roles and wouldn't need to be in SMT.

Shane – I need to be sure you'll drive radical change.

Esther – I'll drive radical change if I'm in the right system. Spend my time doing complaints and invoices. I was set up to fail.

I don't want to be seconded out –you mentioned that Vivienne when we met. I want the chance to do a role, I want a very clear role, and responsibilities and be held to those.

Surgery and ATICS – I'd want that one.

Esther referenced – Deputy Medical Director role – didn't get this noted fully.

I still believe you are trying to move me out.