Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 50 of 2022

Date of Notice: 4 May 2022

Witness Statement of: Peter May, Permanent Secretary

Statement of Truth

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

Signed: __Peter May_____

Date: ___18/08/22_____

Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

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By email only to:

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Our reference: (ref: 5664648)
27 January 2023

For the attention of Christine Smith KC
Chair, Urology Services Inquiry

Dear Chair,

Department attendance at Urology Services Inquiry hearing on 15 November 2022 – follow up response to questions

The Permanent Secretary of the Department of Health, Peter May, and Director of Secondary Care, Ryan Wilson, while providing evidence to the Urology Services Inquiry hearing on 15 November 2022 agreed to provide further written responses to the Inquiry regarding four questions.

I enclose herein the document detailing the Departmental response to these outstanding questions raised at the hearing. I am advised that the Department will upload 29 documents relating to the enclosed response today.

Should you require anything further please do not hesitate to contact us.

Yours sincerely,

Sara Erwin

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Received from DoH on 27/01/2023. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 1 of 2024

Date of Notice: 1 March 2024

An Addendum to this statement was received by the Inquiry on 29 March 2024 and can be found at WIT-107624 to WIT-107946. Annotated by the Urology Services Inquiry.

Witness Statement of: Peter May, Permanent Secretary

I, Peter May, will say as follows:-

1. Since you last gave evidence, the Inquiry has received evidence from Richard Pengelly, former Permanent Secretary at the Department of Health. Do you wish to comment on Mr Pengelly's evidence in any way?

1. I have reviewed the statement and evidence provided by Richard Pengelly. Some aspects relate to specific events of which I have no knowledge, but on the strategic approach outlined I can say that I both recognise and agree with the system approach he outlined. Overall, I am content to agree with the evidence provided by Richard.

Received from Peter May on 22/03/2024. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

Statement of Truth

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

Signed: ____  ___

Date: __22 March 2024_____

Received from Peter May on 22/03/2024. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 1 of 2024
Date of Notice: 1 March 2024

Addendum to Witness Statement of: Peter May, Permanent Secretary

Following on from my written statement submitted on 22 March 2024 and consultation with USI Counsel on 27 March 2024, in order to provide further clarity to the Inquiry, I, Peter May, will say as follows:-

Further explanation as to why the duty of quality was removed following the change from SPPG to HSCB

1. Prior to 2009 the HSS Boards had responsibility for the exercise of social care and children's functions, which they in turn delegated to HSS Trusts to deliver upon.

2. Social care and children functions means the following functions (so far as they are exercisable by HSC trusts under the provisions conferring them)—

   (a) functions under sections 35 and 96 of the Children and Young Persons Act (Northern Ireland) 1968;

   (b) functions under Articles 15, 36, 37, 38, 39, 99, 101 and 101A of, and Schedule 6 to, the Health and Personal Social Services (Northern Ireland) Order 1972;

   (c) functions under sections 1(2), 2 and 12(1) of the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978;

Received from Peter May on 29/03/2024. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

Statement of Truth

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

Signed: ____  ___

Date: __29 March 2024_____

Received from Peter May on 29/03/2024. Annotated by the Urology Services Inquiry.

2 (i) it does not have a Board --

7. SPPG is a group within the Department of Health responsible for the functions of the HSCB which transferred to the Department. As a group of the Department it is directly accountable to the Minister for the exercise of its functions.

8. The Deputy Secretary leading the Group is accountable to the Permanent Secretary for the delivery of its functions, who in turn is accountable to the Minister for the Department's performance.

9. The Group is subject to the same scrutiny as the rest of the Department by the Departmental Board which includes two non-executive members. The Department's Audit and Risk Assurance Committee was established to advise the Accounting Officer, through the Departmental Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. The Committee membership comprises the two Non-Executives of the Departmental Board and a further two independent external members. The oversight of the Committee extends to SPPG and those former functions of the Board which are now under the direction of the Department.

2 (i) nor does the statutory duty of quality apply to it

10. Article 34 (1) of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 [DOH-43905] placed a duty on the then Health and Social Services (HSS) Board (and each HSS Trust) to make arrangements for monitoring and improving the quality of the care it provides to *individuals*. This provision was made to reflect the role of HSS Boards in the delivery of Social Care and Children's functions.

11. In the 2009 Health and Social Care Reform Act [DOH-01621 – DOH-01632] HSS Boards were abolished and the HSCB was established. The Act

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"glossed" references to HSS Boards which meant that where HSS Boards were referred to in other legislation, the Regional Board and/or Regional Agency should be read.

12. In developing the HSC(NI) Act 2022, consideration was taken of other related legislation to ensure alignment and clarity. Reference to HSS Board from Article 34 (1) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 [DOH-43905] was removed. The removal of this provision reflected the position that, as the delivery of Social Care and Childrens Functions had transferred to HSC Trusts, the SPPG did not provide care to *individuals*.

13. With regards to the functions of the former HSCB and now undertaken by SPPG as defined in Health and Social Care Reform Act (2009) [DOH-01621 – DOH-01632] relating specifically to the commissioning, performance and financial management of health and social care services, SPPG has in place arrangements for monitoring and improving the quality of health and social care services. SPPG is supported in this regard by the Public Health Agency (PHA).

2 (ii) unlike the former HSCB, the SPPG is also outside the remit of the RQIA

14. The removal of the reference to HSS Board from Article 35 (9) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 [DOH-43906] was again as a direct consequence of the closure of the HSCB. As per the above, following dissolution of the HSCB, the functions relating to the exercise of Social Care and Children functions were transferred to HSC Trusts.

15. The change in legislation underpins the organisational and operational position that SPPG does not provide care to *individuals* and as such the Regulation and Quality Improvement Authority (RQIA) has no oversight role in that regard.

Received from Peter May on 22/03/2024. Annotated by the Urology Services Inquiry.

16. The new relationship with SPPG is being redefined and will reflect SPPG's constitution as part of the Department and its core functions as set out above.

2 (iii) the PHA, whilst a partner with SPPG in considering commissioning services, no longer has a mandatory decision-making/sign off role in those commissioning services, this statutory role resting only with SPPG.

17. As set out above successive Ministers outlined the need to review commissioning arrangements as the process was bureaucratic and the resource and time required excessive. The *Commissioning Plan* was one element of a suite of products that comprised that bureaucratic commissioning approach.

18. In excluding Section 8 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 [DOH-01633] the Health and Social Care (NI) Act 2022 (a copy is provided to the Inquiry at Appendix 2), removed the statutory requirement for development of a Commissioning Plan.

19. The approach to planning HSC services under the new ICSNI Framework is coming to conclusion and will be considered by an Oversight Board chaired by myself and comprising leaders from across the HSC sector, including the Head of SPPG and the Chief Executive of the PHA, before approval by the Minister.

20. Following the Minister's decision, the HSC Framework document [DOH-35616 – DOH-35672] will be updated to reflect the new commissioning approach, which cements the role of SPPG and PHA in jointly planning and managing health and social care services, following its implementation later this year.

21. In the interim SPPG and the PHA have continued to work together to support the planning and management of HSC services through, for example, effective implementation of agreed care pathways; addressing variation of performance; and service reconfiguration.

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RQIA related recommendations

32. Prior to the COVID-19 pandemic, the Department had developed a new draft regulatory policy framework however further development work is required, including consultation on the draft policy. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context, work on the review of the regulation is currently paused to allow for other priority projects to progress.

INI Recommendations

33. The Department published the overarching Independent Neurology Inquiry (INI) Implementation Plan on 27 July 2023, establishing the themes and workstreams to progress the 76 Independent Neurology Inquiry Report recommendations. A copy of the INI Implementation Plan is provided to the Inquiry at Appendix 5.

34. Since then, work has progressed to outline the specific actions required against each INI recommendation and further engagement with wider INI stakeholders was completed to support this work.

35. The INI Action Plan was published on 7 March 2024, accompanied by a Written Assembly Statement. Copies of the INI Action Plan and Written Assembly Statement are provided to the Inquiry at Appendices 6 and 7.

36. The INI Action Plan outlines a series of coordinated actions across a range of organisations, including the Department of Health, the GMC, Healthcare Organisations, and the Independent Sector. The Plan sets out the actions required to implement the 76 recommendations and outlines the relevant owners and the progress and current status in respect of each recommendation.

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8. Given the current pressures affecting all parts of the health and social care system, do you consider that further regulation is the answer?

75. As I have acknowledged in my response to Question 7, the regulatory landscape is already a complex one with a range of bodies discharging various roles and functions which exert some measure of regulatory influence - either direct or indirect. Further, research and studies in the UK and beyond have acknowledged the vast range of regulatory interventions in healthcare systems more generally, the number of bodies involved and vast resource expended.

76. Further regulation should not be a default option and seeking to introduce more regulation in response to a significant service or system challenge, in particular given current pressures on the system, may not always be the best response.

77. The Department has acknowledged however, that the current legislation underpinning the regulation and inspection of health and social care services, and the role and functions of the RQIA, dates back to 2003. The delivery and provision of health and social care has evolved significantly in the intervening period. A future review of regulation would provide a platform to consider any identified improvements in the regulation and monitoring of services, and to consider what is the right model of regulation across the full system and sectors of health and social care provision.

78. A new draft regulatory policy framework had been drafted prior to the COVID-19 pandemic, however further development work is required, including consultation on the draft policy. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context, while it remains an important identified priority, work on the review of the regulation is currently paused to allow for other priority projects to progress.

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79. There is also a need to balance regulatory intervention with support for learning, improvement and development. The Department is progressing a number of policy strands designed to further support and help embed an open, just & learning culture across our HSC; aimed at better supporting staff and patients and ultimately delivering improved care. This work recognises and takes account of emerging evidence and practice.

80. A core ambition of this work is to further enable an environment which identifies and learns 'system-wide' lessons when things do not go as planned in delivery of care - to deliver system improvement and leading to better outcomes for patients and staff providing services. This is best achieved by creating a psychological safe space supporting staff to engage openly in learning processes as part of an open and learning culture; avoiding a blame culture which is counterproductive. This also supports staff to communicate early with patients and families in a compassionate, open and honest manner. Where an incident or event requires accountability for action, this should be proportionate, just and prompt; taking account where relevant of system factors. An open, just and learning culture which co-exists with appropriate and just accountability is key to support delivery of safe and compassionate care and protecting the welfare of our staff.

81. While not a statutory requirement, HSC staff who are registered with professional regulators are already required to comply with a professional duty of candour.

82. Work underway, led by the Department, to support this policy agenda includes, but is not limited to: an emerging Being Open Framework; the Redesign of the SAI procedure; early work on an underpinning Charter; the recently published Raising Concerns HSC Regional Framework (a copy is provided to the Inquiry at Appendix 7); ongoing review of Maintaining High Professional Standards (MHPS); work due to commence shortly with the Northern Ireland Public

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Sector Ombudsman to review the HSC Complaints Procedure, and review of HSC Occupational Health Services.

83. The Department is also linked into and keeping a watching brief on a range of related strands of work that are ongoing or emerging at national level and is well placed to consider in due course any emerging/ interim learning and final proposals. Again, these include but are not limited to: the Thirlwall Inquiry; The Department of Health and Social Care (DHSC) England ongoing review in relation to the implementation of the Duty of Candour there; developments in relation to a UK-wide review of professional regulation (a United Kingdom Government (UKG) commitment but not substance processing at this time); and work being progressed by DHSC to consider “accountability of senior managers”.

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2 (iii) the PHA, whilst a partner with SPPG in considering commissioning services, no longer has a mandatory decision-making/sign off role in those commissioning services, this statutory role resting only with SPPG.

17. As set out above successive Ministers outlined the need to review commissioning arrangements as the process was bureaucratic and the resource and time required excessive. The *Commissioning Plan* was one element of a suite of products that comprised that bureaucratic commissioning approach.

18. In excluding Section 8 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 [DOH-01633] the Health and Social Care (NI) Act 2022 (a copy is provided to the Inquiry at Appendix 2), removed the statutory requirement for development of a Commissioning Plan.

19. The approach to planning HSC services under the new ICSNI Framework is coming to conclusion and will be considered by an Oversight Board chaired by myself and comprising leaders from across the HSC sector, including the Head of SPPG and the Chief Executive of the PHA, before approval by the Minister.

20. Following the Minister's decision, the HSC Framework document [DOH-35616 – DOH-35672] will be updated to reflect the new commissioning approach, which cements the role of SPPG and PHA in jointly planning and managing health and social care services, following its implementation later this year.

21. In the interim SPPG and the PHA have continued to work together to support the planning and management of HSC services through, for example, effective implementation of agreed care pathways; addressing variation of performance; and service reconfiguration.

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22. Whilst the Department ultimately has approval for the commissioning of services, this could not be discharged without the joint endeavours of both SPPG and the PHA. For example, in recent years, SPPG in partnership with the PHA have reviewed and developed plastic surgery services, introduced post-covid services and progressed the reform of maternity services.

2 (iv)

23. Addressed separately under each heading (i) to (iii) above.

2 (v)

24. There are no other examples.

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of Covid and our focus was on utilising our resource to best effect in managing and responding to Covid for two years. After that, we went into a Rebuild Programme, and I talked about this earlier, where we worked with Trusts in terms of agreeing our recovery from Covid.

In terms of the delivery of high-quality services, I mean, we've talked about this earlier. That sits within the purview of the Health and Social Care Trust, so the targets are part of the picture, but safe quality services sits within the domain of the Health and Social Care Trust. In Mr. Devlin's defence, our demand capacity gap has increased. That was made even worse by Covid. So the provision of high-quality services, as described by Mr. Devlin, had, of course, diminished because we were in a position with ever-increasing waiting lists and, you know, during a period of Covid and recovering from Covid. So I can understand why his perception would be that these things had conflated, but as I mentioned earlier, this is a very complex working environment, with many, many factors coming into play, and it is easy -- or one -- human nature tries to have a cause and effect; very rarely it's that straightforward - in Health and Social Care, it is multifactorial, as I mentioned earlier.

82 Q. Thank you for taking the opportunity to comment on what Mr. Devlin said. I just want to look at some of the ways in which you gather information or have

So, on that basis, I think there are many instances where we have looked to support the development of quality services and we have set aside our need to ensure that targets are met. I mean, one example that springs to mind is, in 2014, we said to the Southern Trust at that stage, we will set aside the requirements under our Service and Budget Agreement in order for you to blue-sky think, as the then-Director of Commissioning termed it, in order for you to blue-sky think in a way that will actually look at transforming your service and developing your service, and the Trust brought forward plans which did genuinely look to be an opportunity for us to make a step-change in that service and further investment was provided at that stage. So I think it's incorrect and I just don't recognise it in that way and, in many ways, I think it's a bit of a two-dimensional sort of reading of the work of Health and Social Care Board and certainly, now, of SPPG. 12:25 12:26 12:26

80 Q. I suppose to be fair to Mr. Devlin, he is no longer around as Chief Executive to see the outworking of some of the plans that were anticipated. 12:26

A. MR. CAVANAGH: Sure.

81 Q. But certainly that was his view at the point of his Section 21. I think you want to say something else? 12:26

A. MRS. GALLAGHER: Indeed. And I suppose just to remind ourselves that the commissioning process was stood down in 2020 before the closure of the Board, for the reasons that I set out earlier; we were in the middle

6. What is your view of the importance of setting appropriate standards around, for example quality and patient safety, for healthcare providers? Who is responsible for doing this? Do you have a view on the effectiveness of any groups, committees or organisations in agreeing these standards?

50. Delivery of health and social care services is increasingly complex. It is in the interests of all stakeholders – including HSC Trusts and other service providers, commissioners, and service users and carers - to try to minimise complexity where possible. The use of standards is one mechanism to help achieve this.

51. The Department of Health's *Quality Standards for Health and Social Care* were published in 2006 [DOH-71901 – DOH-71937]. These Standards remain extant and set out the quality standards that the Department considers people should expect from HSC Services.

52. The five quality themes which make up the standards are applicable to all HSC providers environment whether community, primary, secondary or tertiary care:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social well being; and
- effective communication and information.

53. The Standards provide a measure against which provider organisations can assess themselves and demonstrate improvement, supporting a rise in the quality of services provision. The Standards are also used by the RQIA as part of their inspection and review programme to assess the quality of care provision.

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54. The Department recognises that there are likely to be opportunities and benefits from evaluation and review of the 2006 Standards. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context, work to review the 2006 Standards is not currently planned for the 2024/25 business year.

55. The Department's 2006 Standards are part of a much broader suite of standards, guidelines, policy and practice aimed at improving the quality of health and social care services provided in Northern Ireland.

56. Given the relatively small size of the healthcare ecosystem in Northern Ireland, we do not have the resources to replicate work undertaken by national standard setting bodies and expert groups. To seek to do so would not be good use of public resource. Instead, Northern Ireland is well placed to avail of such standards and to consider these for application in Northern Ireland to protect and improve safety and quality; and to participate in development of such standards. Northern Ireland has local processes and systems for assessing and adopting (or otherwise) such standards when they are developed. Consideration is also given to any unique considerations which would require a bespoke Northern Ireland response, although in reality there are few such factors.

57. One good example of this is the Service Level Agreement (SLA) that NI has in place with the National Institute for Health and Care Excellence (NICE). NICE's role is to improve outcomes for people using the NHS and other public health and social care services in England by producing evidence-based guidance, quality standards and performance metrics and a range of information services for commissioners, practitioners and managers across health and social care. The Department established formal links with NICE on 1 July 2006 whereby guidance published by the Institute from that date is reviewed locally for its applicability to Northern Ireland and, where appropriate,

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endorsed for implementation in Health and Social Care (HSC). This link has ensured that Northern Ireland has had access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions. NICE Technology Appraisals, Clinical Guidelines, Public Health Guidelines and COVID-19 Rapid Guidelines are considered and endorsed for Northern Ireland, as appropriate. In Northern Ireland, HSC Trusts are responsible for implementing NICE guidelines and the Department's Strategic Planning and Performance Group works closely with the PHA to monitor and seek assurance on implementation.

58. There are a variety of other standards and best practice guidelines depending on the clinical service area or professional practice and these will be used at regional and organisational level to inform and underpin service delivery, improvement and transformation.

59. Statutory Professional Regulators, for example the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC), set education and professional performance standards, taking action to improve practice and protect safety and quality where individuals fall short of that standard (this can include for example enhanced training and supervision requirements; put restrictions on practice or ultimately remove individuals from the register and stop them from practising). Professional Regulators are overseen by the Professional Standards Authority (PSA) for Health and Social Care which operates on a UK-wide basis.

60. The RQIA is asked by the Department of Health to regulate a range of services – these include for example, Nursing and Residential Homes, Domiciliary Care Agencies, Day Care Settings and Children's Homes. The RQIA's regulation function is underpinned by legislation (the 2003 order) [DOH-43888 – DOH-43930]. The RQIA uses a range of standards to assess care and services through inspection in discharging their regulatory function.

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20. The responsibilities of Trust Boards are significant. There have been problems in adequately recruiting and retaining and developing Board members at both Executive and Non-Executive level.

(i) Do you have any observations on how Boards could be better supported by better succession planning?

(ii) What are your views on ongoing development and funding to ensure that a Board has adequate resources to attract suitably qualified members, and to enable those members to discharge their duties appropriately?

(iii) Has this issue been discussed and have any proposals been developed in this area?

(iv) Given that every Public Inquiry has implications for Trust Boards, has the department discussed how Boards could be supported to deliver against improvement mandates?

168. Succession planning within the Boards of ALBs is a priority for the Department with end-dates for current appointments actively monitored when planning the order of competitions and reserve lists created and utilised to address vacancies that occur between competitions.

169. Within my Department, the Public Appointments Unit has a comprehensive programme planning process in place. This includes consultation with ALB Chairs on issues such as monitoring term end dates, agreeing extensions to terms and second term reappointments, competition scheduling and, once competitions are completed, agreeing the commencement date for new appointees. Where possible, Board appointments are sufficiently staggered to ensure that there is appropriate retention of experienced Board members balanced by the influx of new members bringing fresh challenges.

170. The Department of Finance requires all public appointees, as a condition of their appointment, to attend an induction course “Essential Skills for Board Members” or the “On Board Training Programme for Board Members of Public Bodies in Northern Ireland” within 6 months of taking up appointment. This

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training is in addition to any relevant training available from the HSC Trust. In addition the HSC Leadership Centre has recently started to offer Non Executive Training and I attended a recent module as the Departmental representative to provide an insight regarding the Departmental approach and expectations.

171. Primary responsibility for providing the resources required to enable Board members to discharge their duties appropriately lies with the individual HSC Trusts within the overall funding provided by the Department of Health. As with all public spending decisions it is important to recognise the opportunity cost involved, with the provision of more resources for HSC Trust Boards implying that less is available for frontline service delivery.

172. In terms of the attraction of suitably qualified members to HSC Trust Board positions. The position of a HSC Trust Non-Executive Chair requires a time commitment of three days per week and attracts a remuneration of £33,047 per annum. HSC Trust Non-Executive Director positions require a time commitment of one day per week and attract a remuneration of £8,883 per annum.

173. Publicity and outreach are tailored to suit each competition, in order to achieve the best possible spread of applicants, including efforts to attract applications and increase diversity. The most recent competition to recruit 16 Non-Executive Directors across six HSC Trusts launched in June 2022. A total of 107 applications were received. Following a review of the applications received, two were excluded. This implies that there were around seven valid applicants for every post suggesting that there is not a particularly significant issue in the attraction of candidates to HSC Trust Board positions.

174. The daily fees for Chairs and Members of Public Bodies and holders of broadly similar appointments are reviewed annually, in accordance with wider public sector pay policy, and increased with reference to the pay award for all non–

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organisations.

113 Q. And who is responsible for that?

A. For the Non-Executive Directors, that sits with the Department of Health.

114 Q. Why has there been no succession planning if self-evidently time periods of tenure are going to expire and it is foreseeable that there will be difficulties, why do you think there has been a failure to bring about succession planning? 12:43

A. I honestly, I would only be giving you my thoughts, I don't know why it hasn't been. But I suspect that, in the scheme of what the department does, it is not up there in the top 10 things to keep an eye on. But from where I sit as a Non-Executive Chair of the Health and Social Care Trust the leadership of the Trust certainly is in my top three every day of the week. So I would be encouraging the Department to ensure succession planning was appropriately planned for from here on in. 12:44 12:44

115 Q. On one view, when one looks at that handbook, the detail and the expectation, the legal responsibilities, the statutory responsibilities and the governance responsibilities, it could be argued that it is difficult to see why keeping Boards fit and healthy and filled would not be something that would be in the Department's best interests? 12:44 12:45

A. These are not attractive roles. You've got to want to do this. You don't step into a Health and Social Care Trust as a Non-Exec because you have some time on your hands. You do it because you want to bring your

skills, your experience and your absolute commitment to health and social care to the table. I firmly believe, and it is with my Boardroom Apprentice and other hats on, people want to serve, they want to learn to do that, so let's create the space for people to be able to serve on our Health and Social Care Boards and get that right at the beginning. Succession planning needs to be thought about the moment you appoint somebody. The senior executive team succession planning, I know from talking with our current Permanent Secretary Peter May, this is something he has focused on, something he has focused on in relation to the training and development of Non-Executive Directors and that induction piece, that is on his agenda and he is watching it and he wants that to happen. We need to think of how we make these roles, not just Non-Exec, but the senior executive roles attractive to encourage people to apply, because they are incredibly rewarding. 12:45 12:45 12:46 12:46 12:46

116 Q. When you have a turnover at Chief Executive level to the extent that was apparent in the Southern Trust, is there a danger or possibility that the Chair, whether it be you or the former Chair Mrs. Brownlee, who will come and give evidence and answer questions herself, but is there a possibility that either advertently or inadvertently they become more involved in operational decisions because they have corporate memory or because they need to fill a gap that may exist at any time?

A. Absolutely. We talked earlier about Roberta Brownlee's tenure with the Southern Trust and within the Southern

finding the time to provide for their development needs? Maybe they're not issues at all, but are there any particular challenges in relation to the composition of your Board that you regard as risks?

A. So, some of the membership have recently changed and they do come from a variety of backgrounds, which I think, you know, it's not yet as diverse, I think, as it needs to be. But, you know, I know that that's the aspiration. And I think that, you know, it's always about getting the balance between having enough knowledge about health and social care and accountability mechanisms to be able to do that part of it. But also then to be able to think differently so that you can actually challenge the status quo, which is also really important. So I think I am beginning to see that in different ways in terms of the questions that come through. I think they need to get to a position of stability with full Board compliment and I think, yo know, their time is always pressurised, you know because there's a day of month - the most of a day a month taken up with the Trust Board, you know there are the statutory visits to children's homes which we get feedback on which is really helpful, and then we try to do the leadership visits around, and then chairing committees and attending to committees. So their time is really heavily used and I think, you know, ideally if we had more of their time I think it would bring even more value to the system, but the way it's constructed at the minute that's not where it is,

16:21 16:22 16:22 16:22 16:23

you know.

219 Q. Can the Department do anything to assist Trusts in this respect?

A. It's possible. I know that certainly, you know, the foundation Trust structure in England is different in that there are councils and there are Trust Boards, and there's probably a lot more input from the public, you know. But again, you know, we're - I imagine one of the limitations on this is we are working in a really financially restrictive environment currently and all of these things obviously have to be accounted for. But certainly, you know, anything at all that can add to the breadth and depth of the expertise and the time allowed to the Non-Executives I think would be welcome. 16:23 16:23

220 Q. Clearly a strong Trust Board, strong Non-Executive Directors, could have the potential, viewed from one perspective, to make life difficult for executive directors and leaders, such as yourself. From your answers you would wouldn't appear to see it that way. What do you see as the value of a strong set of Non-Executive Directors for the overall health of the organisation? 16:23 16:24

A. I think it's the informed challenge position, and that's really important. And, again, back to, you know, the issue of blind spots, being able to see things that we can't see because we're caught up in the day-to-day business, that's really important in terms of, you know, helping us to stay safe as an organisation in terms of patients. 16:24

4. What is your view of the importance of enabling a health and social care information system that can be used by organisations to drive improvements in safety, quality and performance, and inform integrated governance at each level of the system? Is such a system envisaged? If so, please set out full details.

30. The Framework Document 2011 [DOH-35616 – DOH-35672] sets out the extant roles and responsibilities and arrangements for discharging same across the Department and health and social care system (HSC).

31. The use of information systems to drive safety, quality and performance operate at a range of different levels and require both ready access to the right data and the ability to combine a variety of datasets to provide a complete picture. For example, in relation to how HSC Trusts are overseen, during 2023/24, the Department tested the use of a Balanced Scorecard approach at the Ground Clearing meetings which were held in preparation for subsequent Accountability Meetings with the HSC Trusts. This approach is expected to involve the extraction of pertinent information from a wide range of systems to support a holistic view of Trust performance as part of Accountability Arrangements across a number of domains, including for example: performance; safety and quality; patient experience; and productivity and efficiency.

32. The Balanced Scorecard approach will be evaluated before any decision to embed this as a new process to support Departmental Accountability arrangements with HSC Trusts.

33. Looking at how clinical information is joined up, the successful introduction of the Electronic Patient Record (EPR), at the heart of the encompass programme, required a review and standardisation of clinic pathways by healthcare professionals. Going forward, the information from the Acute and Community Care sectors that the EPR makes available will significantly

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enhance the drive for improvements in safety, quality and performance and inform integrated governance, and will complement existing data and information systems. The system will provide “near real time” data which can be used to benchmark HSC Acute Care and Community Care services across Northern Ireland, and with other Epic System users in the UK and Worldwide.

34. The HSC Digital Strategy HSC Northern Ireland 2022-2030 (a copy is provided to the Inquiry at Appendix 4) describes the role of digital solutions in achieving the ambitions set out in the Health and Wellbeing 2026 - Delivering Together Strategy [WIT-50918 – WIT-50945]. That strategy specifically notes the contribution of standardised pathways, powered digitally, to improve the consistency, quality, and safety of care being delivered across Northern Ireland.

35. The standardised information collated by the EPR and the ability to benchmark service outcomes with other UK Epic installations will, in association with analysis from the nascent HSC Data Institute (as described in the HSC Digital strategy), provide an initial insight into the performance of HSC services and further capability for Trusts to drive improvement.

36. SPPG will work closely with Encompass Teams and the planned Data Institute, as appropriate, to improve and enhance regional performance information oversight capabilities in line with Departmental priorities.

37. HSC Trusts have a statutory responsibility to put and keep in place arrangements for the purpose of monitoring and improving the quality of services to individuals (Article 34 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003) [DOH-43905].

38. To assist in discharging this statutory duty, HSC Trusts must ensure that they have appropriate organisational management, clinical and professional

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5. Can you explain the purpose of the Encompass system, and outline its state of development, the extent to which it has been 'rolled out', how it functions and how it is intended to benefit health and social care organisations, their staff and their patients/carers. What is the timescale for the introduction of Encompass throughout Northern Ireland and, in particular, the SHSCT? Is it envisaged that the Encompass system has the potential to drive improvements in safety, quality and performance?

42. The encompass programme is a clinical and operational transformation programme with an electronic patient record solution (EPR), supplied by Epic, at its heart. NI is the first system to adopt this unified approach to an electronic health record at Integrated Care System level and is the first in the UK to incorporate Social Care as part of this endeavour. It is the largest implementation of the Epic Platform in Europe.

43. The flagship programme will see encompass replace or link with the vast majority of clinical systems currently in operation in Acute and Community Care settings, replacing existing, often "end of life" Patient Administration Systems (PAS) and clinical record systems across HSCNI. The EPR will provide those working in Acute and Community Care with a single, holistic, appropriate view of a patient or service users' interactions with those sectors. Primary Care professionals will also have appropriate access to the information.

44. The programme will change how staff work at all levels across HSCNI, whether clinical, operational or in supporting roles. The programme is unique in that it incorporates secondary health care, community nursing, mental health and social care.

45. The solution will include a patient portal (My Care) enabling patients and service users to view letters and results, and to take more control over their care. My Care is available as a mobile phone app or through a web browser

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21. Please add any further information which you feel may be of benefit to the Inquiry.

Reform of Maintaining High Professional Standards (MHPS)

Background

176. Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS [WIT-43684 – WIT-43731], was published by the then Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. It was modelled on a document titled "Maintaining High Professional Standards in the Modern NHS" which was first issued in December 2003 by the English Department of Health. The Northern Ireland MHPS document was effective from 1 December 2005 and remains in force.

177. The Department has a limited role in the application of MHPS and has limited knowledge of how HSC employers operate in practice. As set out in my previous statement to the Inquiry, two reviews were initiated relating to reviewing the MHPS Framework - but were not completed. Neither review proceeded to a conclusion and no changes were made to the document.

178. A review of MHPS commenced within the Department in 2023 with the establishment of an Independent Review Panel under the direction of the MHPS Review Steering Group. This panel consist of 3 individuals who are external to the Department of Health/HSCNI. Each bring differing expertise to the project covering: Operational Experience of the MHPS Framework; Medical Leadership/Governance; Employment Law/Rights Knowledge; and Restorative just & learning practices.

The Review to Date

179. The Independent Review Panel carried out their engagement phase of the project between July and December 2023. This intense stakeholder

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engagement took the form of written submissions made by the key stakeholders and face to face engagement sessions with key stakeholders to discuss in detail the operation of the current MHPS framework locally.

180. The Independent Review Panel are currently considering all evidence, views and thoughts that have been gathered during stakeholder engagement, along with the recommendations and observations on the Independent Neurology Inquiry and the Urology Services Inquiry and the work carried out on the previous reviews.

Outcome of the Review

181. An initial working draft report will be produced and presented to the Steering Group by end of March 2024. This will contain the review panels initial key findings and recommendations on the way forward for MHPS within the HSC. It is hoped the final report will then be presented to the Department by June 2024. A copy can then be shared with the Inquiry once published.

Observations from the Review Panel

182. The Review Panel have not as yet finalised their recommendations but there are four main themes which the panel will be providing observations and recommendations on:

- The purpose of MHPS
- The MHPS process
- Roles, Responsibilities and Rights of those involved in the process
- Oversight, Governance & Accountability

<u>Redesign of Serious Adverse Incident (SAI) procedure</u>

Background

183. A redesign of the current Serious Adverse Incident (SAI) Procedure [DOH-00163 – DOH-00270], is progressing, led by the Department. This will result in a new Framework replacing the current SAI procedure. SPPG and HSC

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Trusts, amongst a range of other partners, sit on the programme board (Redesign Development Group).

184. The programme of work will seek to address relevant recommendations arising from the IHRD and the INI, alongside recommendations from the RQIA Review of Systems and Processes for Learning from SAIs which together have provided a clear and strong evidence base underpinning the need to refresh and redesign the current approach to learning following SAIs.

185. The SAI Redesign programme is being progressed by a Redesign Working Group (RWG) and a Redesign Development Group (RDG). Membership of these groups comprises senior colleagues from the Department and from the HSC, including Trusts.

186. This programme of work will introduce a new Framework to deliver learning and improvement from patient safety incidents/events through a new streamlined and simpler review process.

187. The Departmental work will not focus on reviewing and refreshing all local systems across HSC Trusts and delivery areas. Rather it will deliver a clear, overarching regional Framework together with supporting methodologies, learning and improvement tools, and relevant guidance.

188. It is anticipated the new Framework will deliver a fundamental change in how HSC organisations review and learn from patient safety incidents, resulting in improved care. The new Framework and supporting guidance will be less detailed and prescriptive in many aspects, in contrast to the current SAI procedure.

189. Areas of key focus for the current phase of the SAI Redesign work include:

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- Further Involvement and co-production activity with both patients/ families and staff, and wider stakeholders to seek views and to build confidence in emerging proposals;
- Redefine and rebalance the oversight and assurance functions (local and regional) as part of the new Framework and how these will work in practice – achieve correct balance between greater organisational autonomy and flexibility, and redefined organisation and regional oversight and assurance roles;
- Further drafting of the new Framework and supporting guidance;
- Opportunities for managed prototyping aspects of the emerging Framework; and
- Planning to deliver a managed transition to new Framework.

190. The policy team is targeting a consultation on the new Framework in Autumn 2024.

Review of Early Alerts

Background

191. On the 15 November 2022 I committed to a review of the Early Alert system when giving evidence at the Urology Inquiry. In summary I noted:
"… the way in which information of concern flows to the Department is, broadly speaking, through the Early Alert System, ... there is inevitably a risk that, over time, the filter that is supplied in relation to Early Alerts can get broader more things than go through the filter and more Early Alerts are raised … there's always going to be a risk that something doesn't come forward because people don't feel it does meet the terms, or perhaps is not recognised for the significance …. I think that a review of the nature of that sort is something that I could advance in the absence of a Minister… What we are trying to do is make an existing policy work properly, as it were, rather than create a new policy."

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192. Due to resourcing pressures this work has not yet substantively commenced though some early planning has taken place. It is currently anticipated that a review of the Early Alerts Process will be undertaken by the Department in 2024.

Lookback Review Guidance

193. The Department issued Safety Quality and Standards circular HSC (SQSD) 2021 in July 2021 [WIT-51572 – WIT-51585]. This contained new Regional Guidance for Implementing a Lookback Review Process. This guidance was produced by SQSD on foot of recommendations from the Hyponatraemia Related Deaths Inquiry.

194. The RQIA commented in their interim report into the review of the Urology Lookback Review in the SHSCT that there is a need for the collective experience and new knowledge derived from the various lookback events to be captured to inform future iterations of the Regional Guidance. The SHSCT have said on a number of occasions that this guidance should be reviewed urgently, while relevant expertise and experience with the guidance and carrying out lookback reviews is still held within the various Trusts.

195. A review of the Regional Lookback Review Guidance has been agreed and the completion of this work will be subject to staff resource availability.

Urology GIRFT

196. In February 2023 the Department commissioned the Getting It Right First Time (GIRFT) [DOH-72314 – DOH-72364], team to complete a review into Urology services. One of the key reasons for undertaking this review was to ensure that recommendations could be identified and implemented at the earliest possible opportunity to facilitate the improvement in the extensive waiting lists in this area and to ensure that patients are treated as quickly as possible to ensure best possible outcomes.

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197. The key aim of the review was the configuration of services to maximise capacity in the HSC system to secure sustainable service delivery and more effective patient throughput in line with the Elective Care Framework [WIT-51386 – WIT-51461], and the Cancer Strategy [WIT-51192 – WIT-51329].

198. The report highlighted areas of good practice across the HSC system, for example around the development of regional services. There is a clear sense that there is much good work going on that can be expanded and that there is a willingness among clinicians and other staff in the service to transform and deliver an excellent service.

199. The report has identified a series of 40 recommendations to improve the service, in addition to a list of recommendations for each HSC Trust. These recommendations have been accepted in principle by the Department. Work is already underway on many of the recommendations; however, others will require funding and resources. The recommendations focus on the themes of maximising surgical assessment/diagnostic capacity and improving efficiency, strengthening pathways and protocols, exploring non consultant grade skills mix and training and regionalisation/specialisation of services.

200. Funding requirements have yet to be fully quantified but will include investment in the workforce, which includes creation of additional posts and training of staff, along with capital funding for equipment and infrastructure.

201. The context and recommendations of this review very much align with established policy on elective care as set out in the Elective Care Framework, in terms of driving productivity, streamlining pathways, maximising skills mix to tackle lengthy waiting lists.

202. The Department is engaging with relevant stakeholders to take forward implementation of the recommendations.

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89. Leadership and culture are also important ingredients in driving effective change.

90. As set out more fully in response to question 11, the HSC Performance and Transformation Executive Board (PTEB) brings together leaders from across the Health and Social Care system to bring a collective approach to driving change. Similarly, as also detailed in the response to question 11, the Expert Clinical Panel (ECP) brings together senior clinicians to collectively consider key transformation initiatives. There is also an ongoing commitment within the Health and Social Care Workforce Strategy 2026 (a copy is provided to the Inquiry at Appendix 8) to "Continue to align and support a collective leadership culture within the HSC through the full implementation of the HSC Collective Leadership Strategy" (a copy is provided to the Inquiry at Appendix 9). This action is the responsibility of HSC employers. Also, as detailed in response to question 19, HSC Trusts devote resources to learning and development, which include support and training for staff taking on leadership roles.

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10. Given the workforce challenges, the exponential rise in demand, and the accentuation of problems since the pandemic, what do you see as the role of the Department in supporting a shift in the development of the workforce? How can the Department create better workforce sustainability? Do you consider that the suggested workforce crisis in and of itself, is a strong lever to force a new strategy for health and social care in Northern Ireland?

91. The Department's ambitions for the development of the health and social care workforce are outlined in the 'Health and Social Care Workforce Strategy 2026: Delivering for our People' which was published in May 2018 (a copy is provided to the Inquiry at Appendix 8). This was in response to a recommendation in 'Health and Wellbeing 2026: Delivering Together' [WIT-50918 – WIT-50945] the outworking of the expert panel led by Professor Rafael Bengoa tasked with considering the best configuration of Health and Social Care Services in Northern Ireland.

92. The Workforce Strategy was developed through detailed engagement with stakeholders from across the HSC and independent, voluntary and community sector healthcare providers and trade unions, and covers the period 2018 to 2026.

93. The aim of the Strategy is that by 2026 we meet our workforce needs and the needs of our workforce. To achieve this aim, three objectives have been set:

    i. By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise;
    ii. By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported; and
    iii. By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively and be able to take proactive action to address these before problems become acute.

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- take action to protect people who use services; and
- speak with an independent voice, publishing views on major quality issues in health and social care.

15. Activities they regulate include the treatment, care and support provided by hospitals, GP practices, dental practices, ambulance services, care homes and home-care agencies. They are also responsible for monitoring and reporting on the use of the Mental Health Act (MHA). They also assess ICSs and local authorities under Part 1 of the Care Act (2014). A copy of Part 1 of the Act is provided to the Inquiry at Appendix 1.

16. CQC and NHS Commissioning Board have a partnership agreement (provided to the Inquiry at Appendix 2), to commit to a common purpose to improve outcomes for patients. In terms of their statutory relationship as outlined in Annex A of the agreement CQC can carry out an investigation where it considers there is a risk to health and safety or welfare. Its inspection powers extend to NHS health and social care providers and commissioners of health and social care, including the NHS Commissioning Borad and Clinical Commissioning Groups.

The Department's progress on implementing recommendations from previous public inquiries

17. In April 2023, the Department agreed to formally amalgamate the Hyponatraemia Related Deaths (IHRD) and Independent Neurology Inquiry (INI) Programme Management Boards into a single DoH Inquiries Implementation Programme Management board (IIPMB). A copy of the Terms of Reference is attached at Appendix 3**.**

18. This decision recognised significant commonalities, synergies and shared themes across recommendation from both Inquiries and accordingly the work

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of both Boards. It was considered the amalgamation into the IIPMB had the potential to realise a number of benefits including:

- consistency of approach to implementation of recommendations where relevant;
- implementation and reporting on a thematic basis rather than consideration of recommendations across programmes;
- improved use of existing knowledge, skills and experience of Board members to help realise strategic alignments;
- improved use of project/ secretariat resource across policy teams, minimising duplication of effort and helping to streamline reporting and planning; and
- enhanced collaboration, communication and alignment across policy teams.

19. The first meeting of the IIPMB took place on 21 April 2023. The IIPMB Terms of Reference will be kept under review and will be refined and revised as appropriate.

20. The IIPMB will also explore if appropriate and how best to bring oversight of the implementation of recommendations from other Public Inquiries (such as the Infected Blood Inquiry, Urology Services Inquiry and Muckamore Abbey Hospital Inquiry) under the scope of IIPMB in due course. The importance of integrating the implementation work streams being progressed by external delivery partners is recognised by the Department. This includes engagement and collaborative working between the Department, the Healthcare Organisations, the General Medical Council (GMC), and the Independent Sector organisations as well as partnership working with other relevant organisations.

21. Input and leadership are provided from policy teams across the Department to take forward the substantive policy work required to implement the

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