has also received from the Audit Committee an internal audit report on Mr O'Brien's private practice where governance matters related to this Committee.

45.4 In my view, knowing what I know now, the Trust Board and the Governance were not kept appropriately informed in the period 2016 – 2020. This included explicitly detailing the patient safety risk arising as a result of the demand:capacity mismatch. Since Dr O'Kane, as Medical Director, raised matters at the Trust Board in August 2020, I believe that the Trust Board and the Governance Committee has been kept appropriately informed. The Governance Committee has also been kept informed in regard to improvements being made in reporting, in particular in respect of the MHPS process and professional governance.

Learning

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

46.1 Looking back across my tenure, through the lens of what has evolved to my knowledge since 2020, it is clear to me now that the Trust's governance systems were not fit for purpose.

46.2 At the center of this unfitness is what appears to me to have been a lack of triangulation of information and/or a culture of working in silos. Separate processes were being undertaken with no joining up of the intelligence – MHPS, Appraisal, and Serious Adverse Incident investigations. There was also an unhealthy churn in the key roles of CEO, Medical Director, and Acute Director over the period 2016 – 2020, which did not help matters.

46.3 I did not raise any specific concerns about the governance systems at the time. However, I did raise the below areas for consideration because I believed that

they would support the Trust Board in its learning from others and in its development of the Board Team.

Concern	Raised with	When	What was done
Knowing our blind spots	Roberta Brownlee and Shane Devlin.	27 August 2020	Workshop -Muckamore Abbey Hospital – Report of the Independent Leadership and Governance Review.
Email and note sent to Chair and NEDs as I would not be in attendance at the meeting. NED Sub Committee Membership/Other interested areas/Roles and responsibility	Roberta Brownlee, all Non-Executive Directors, and copied in Shane Devlin.	20th May 2019	No reference in the minutes that this was discussed.
Chief Executive performance targets	Roberta Brownlee and Non-Executive Directors.	28 October 2018	I requested Culture be placed as part of the CEO performance targets.

46.4 As Chair of the Governance Committee, I also sought improvements to reporting, in particular in respect of clinical and social care governance. This was ongoing with each Committee meeting highlighting the need for additional/different information to support its work. Each of the three Medical Directors (2016 – 2019) had their own way of reporting. Dr Maria O'Kane brought significant changes to reporting and practice with the outworking's of the Champion Review. This included Standards and Guidelines, SAI Process, and Complaints.

Please see:

33. 20200827 E to RB and SD Re Blind Spots

225. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019

226. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019 A1

78. 20190521 - Notes of a meeting of the Non Executive Directors and Chair

228. 20181028 E from EM to RB and NEDS re CX Performance Targets 1718 and 1819

229. 20190201 E re Governance Mtg and Papers

47 Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

47.1 I am now aware of governance concerns arising out of the provision of urology services as follows:

Concern	Summary
Concerns regarding Mr O'Brien prior to the MHPS Process	I am now aware that there had been concerns about aspects of Mr O'Brien's practice for several years prior to the institution of the MHPS process in late 2016 / early 2017. It appears that there was a failure to grapple successfully with these issues or to escalate them. I am unsure as to whether these concerns in and of themselves ought to have made their way up to Trust Board or its Committees. However, the failure of Trust systems to resolve the concerns, and their continuation for years as a result, probably ought to have come to the attention of the Governance Committee at an appropriate point.

MHPS Process	The absence of detailed reporting of MHPS cases, and providing the right route for this information to make its way to the Trust Board, is a concern of which I am now aware. The Trust Board or its Governance Committee should have been made aware of the progress of the MHPS process, the difficulties experienced in the MHPS process, the issues with Mr O'Brien's adherence to his action plan, the outcome of the MHPS process, the implementation of the Case Manager's recommendations, and the issues with Mr O'Brien's adherence to the action plan after the Determination.
Under-resourcing with governance support functions	Whilst it is correct that the Chief Executive (Shane Devlin) had raised concerns about under-investment in governance within the Trust and that the Champion Review along with Dr O'Kane had started the process to identify where governance needed strengthening and change, I believe that I wasn't aware of the scale of governance deficit that has become apparent through the Inquiry. This information ought to have been brought to the attention of the Trust Board.
Early Alerts	Early Alerts were not consistently issued to all Board Members prior to September 2020. I believe that the Early Alert system is as important to the Trust Board as it is to the Department of Health. The Trust Board should therefore have received all Early Alerts including, in particular, that dated 31st July 2020.
Declaration of conflict of interest and	I was unaware of the extent and depth of the relationship between Mrs Brownlee and Mr O'Brien. When I now consider the

management of it	Confidential Trust Board meetings and the meetings between Chair, CEO, and NEDs, between August 2020 and the end of November 2020, I see an inconsistent approach by the former Chair - from making no declaration of interest at one meeting to declaring an interest and leaving another meeting to denying an interest yet still leaving yet another meeting. As a result of evidence now before the Inquiry, it appears to me that there was a clear conflict of interest for the former Chair. The Trust Board should have been made aware of the extent and fullness of the relationship between her and Mr O'Brien. At the October 2020 meeting, when I realised there was more to this issue, a very simple Google search revealed to me that the former Chair and Mr. O'Brien had governance roles in a charity. At this point, the Chief Executive (Shane Devlin) raised the conflict with the former Chair. The Northern Ireland Audit Office defines a conflict of interest as: *"A conflict of interest involves a conflict between the public duty and the private interest of a public official in which the official's private-capacity interest could improperly influence the performance of his/her official duties and responsibilities."* It further explains: a) *The interest in question need not be that of the public official or Board member themselves. It can also include the interests of close relatives or friends and associates who have the potential to influence the public official or Board member's behaviour.*

Please see:

230. NIAO Conflict of Interest Good Practice Guide 2015

231. 20170109 Email trail between R Brownlee and J Wilkinson re Designated Board Member

48 Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

48.1 I have attempted to summarise what I believe are a number of key problems in this regard below.

• Not dealing with the issues fully or in a timely way	➢ Issues in Mr O'Brien's practice, which were known about prior to 2016, appear never to have been properly addressed in the period prior to 2016. ➢ On the 30th March 2016, whilst Mr. O'Brien was advised in writing by both his AMD and AD of clinical governance and patient safety concerns, the issues raised with him continued to go unresolved. ➢ An MHPS process, not commenced until very late 2016 / early 2017, was protracted and failed to examine what we now believe were all of the issues with Mr O'Brien's practice. ➢ A number of related SAI investigations (those chaired by Dr Johnston) appear also to have been unnecessarily protracted. ➢ There appear to have been delays in addressing and/or escalating issues with Mr O'Brien following completion of the MHPS process in late 2018 including, for example, his failure to adhere to the standards expected of him in his return-to-work action plan.

	all relevant evidence, including that from the former Chair and Mr O'Brien.
• Role of the Non-Executive in the MHPS process	➢ There was a clear absence of clarity and training in this role for Non-Executive Directors.
• Culture	➢ There was a culture of work arounds for Mr. O'Brien which allowed for issues not to be addressed. ➢ The culture was not sufficiently open, transparent, and safe to allow for the bringing forward of issues and raising of concerns without fear. This criticism applies both inside and outside the Boardroom.
• Instability at Senior Management Team Level	➢ Between 2016 and 2018, there was a series of interim/acting CEO and Director roles across the senior management team. Looking back, this created a risk that no one was taking proper ownership of and responsibility for issues. This, in my view, has been detrimental to the workings of the Southern Health and Social Care Trust.
• Escalation of issues of concern and patient safety	➢ Escalation of issues to Committees and Trust Board was not as prevalent in the past as it is now. Committees and Trust Board require Directors to be open and to raise issues and escalate appropriately. In my view, there were failures to raise with the Board and its Committees issues that ought to have been raised regarding Urology and Mr O'Brien.

	➢ Equally, I believe there were missed opportunities for the Board to be more curious and to probe Directors. For example, on the 27th January 2017 there was an opportunity for the Trust Board to ask questions regarding the consultant who had been excluded from practice. Similarly, after the 27th January 2017 there was no follow up or follow through on this issue from the Trust Board or any of its Committees.
• Demand outstripping supply	➢ The Southern Trust, like others HSC Trusts, has seen a decline in Consultant and Nursing staff over the last number of years. The pandemic has exacerbated this somewhat. There has also been an increase in demand for services. With this increase and the challenges of recruitment it meant that the Urology Service (as with other services) was under immense pressure. ➢ The impact on this is for the patient can be significant and wide-ranging - delay in being seen, delay in investigations being undertaken and diagnostics carried out, and delay in treatment when needed. Ultimately, if the above steps are not carried in a prompt way, (further) harm can be caused. I can also appreciate the potentially greater impact that can be caused by a shortcoming such as a failure to triage a referral letter in a service where there may be a very significant difference in the waiting times for red flag and routine patients.

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

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

49.1

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

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

	threat to any organisation. The churn in Interim and Acting CEOs and Interim Directors during the 2016 – 2018 period had a huge impact on the Southern Trust. Succession planning for Board and Senior Management is required to ensure the organisation does not experience this type of flux again. ➢ Having substantive Executive and Operational Directors provides for stability, ownership, and individual and collective responsibility.
Committee escalation to Trust Board	➢ Creating a written Committee Chair Role Specification, with guidance on escalation from Committee to Trust Board, has been a necessary development. ➢ As has been the specific inclusion within the Committee Chairs' Reports of items for escalation to Trust Boa
Oversight of the role of Chair of the Trust Board	➢ A Senior/Lead Non-Executive Director role should provide a designated point of contact for all Board Members and Directors who have concerns about the Chair as part of broader remit to provide a level of oversight of the role of Chair. This is common practice in Boards within Great Britain.

50 Do you think there was a failure on the part of the Board or Trust senior management to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

50.1 As a Non-Executive Director from 2016, and apart from the Board being advised on 27th January 2017 of an MHPS process being commenced against a Urology Consultant, I was not made aware of any clinical concerns or patient safety issues regarding urology services by the Chair of the Board, by any of the Chief Executives (interim/acting or substantive), by the Medical Directors or by the Operational Directors up until the 27th August 2020.

50.2 The Chief Executive is the most senior executive member of the Trust Board. As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, the Department of Health, HSCB, and ultimately the Minister for the performance and governance of the Trust in the delivery of safe, high-quality care, responsive to the needs of the population in line with prevailing performance standards and targets. In this regard, I would have expected the Chief Executive to raise with Trust Board issues of concern such as the MHPS progress and outcome, the related SAI investigations and their outcomes, and the significance of the demand:capacity mismatch issues within Urology (in particular, the potentially significant impact the demand:capacity mismatch could have upon patient safety in a number of different ways). The Trust Board may then have delegated them to the appropriate Committee for oversight on progress. Such issues (save for the 27th January 2017 meeting mentioned above) were not raised by the interim Chief Executive Mr. Francis Rice, by the Acting Chief Executive Mr. Stephen McNally, or by Mr. Shane Devlin (until after Dr O'Kane had raised them in August 2020).

50.3. Dr Maria O'Kane did raise the concerns regarding Mr O'Brien from August 2020 during her tenure as Medical Director. As Chief Executive, she has continued to raise concerns to Trust Board.

50.4 The Medial Director, as an Executive Member of the Trust Board, has responsibility to advise the Trust Board and Chief Executive on all issues relating to the professional Medical workforce, clinical practice and quality and safety outcomes. The Medical Directors (Dr Wright and Dr Khan) were aware of the issues leading up to and post exclusion of Mr. O'Brien and did not raise these concerns with the Trust Board (save for the single instance on 27th January 2017). I believe that the issues and concerns should have been raised with the Trust Board by them

on more than this single occasion and they could then have been delegated to the Governance Committee for oversight on progress.

50.5 As a Board, there was an opportunity on or after the 27th January 2017 for us to raise questions when informed about a Consultant who had been excluded from practice for 4 weeks. The Board (which included me) asked no questions (or none of any significance that I can recall). At that time, I did not fully understand the MHPS process, nor the need for detailed reporting through to the Trust Board and/or its Committees. Nonetheless, we as a Board should have been more curious. This was a missed opportunity on our part.

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

51.1 I touched upon what I believe were mistakes and/or missed opportunities on my part and the part of others in previous answers such as those at Questions 47 to 50 above. To a large extent, what could or should have been done differently is apparent from my description of the relevant mistakes and/or missed opportunities above. Nonetheless, and in ease of the Inquiry, I have outlined below a number of particular points where I consider that things could have been done differently.

Concern	What should or could have been done
MHPS Process	A clear MHPS process, with clarity of understanding of roles and realistic timelines, could have supported an expedited process rather than protracted one. The inclusion of routes for escalation to Senior Management and the Trust

description of the issues and concerns raised. Please also include all documents relevant to your answer.

26.1 During my tenure Urology concerns and issues (other than in respect of Mr O'Brien) brought to my attention and the Board's attention are summarised below:

Meeting	Agenda Item	Detail
Trust Board Meeting 30th November 2017	9 Operational Performance Director of Performance and Reform • OGI Performance Summary at the end of October 2017 (report summary sheet)	Waits on Cancer pathways: 62-days- patient continue to be in excess of the 62-day pathway target, associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper and lower gastro-intestinal (GI) specialties. In September 18 patients breached the 62-day, with the majority within **Urology 44%** (8 out of 18) and the in the Lung; Skin; UGI; Colorectal; and Gynae tumour site.
	• Corporate Dashboard	Cancer Pathway 62 Days (Reported one month in arrears) Performance in 2016/2017 demonstrated a decrease in comparison to 2015/2016 (88.30%) and based on the performance projects this year an improvement is not anticipated. This is associated with an increased level of patients on the pathway with increased demand on the resources available, include red flag out-patient and diagnostic capacity. The percentage of confirmed cancers has not demonstrated a disproportionate increase. The majority of 62-day pathway breaches for the Trust continues to be within **Urology**,

		one of the four tumor sites with greatest demand.
Trust Board Meeting 25th January 2018	12.i Operational Performance Director of Performance and Reform • Performance Dashboard (Ministerial Targets) as at December 17 Report Summary Sheet	Waits on the Cancer Pathway: (31 and 62 day targets 62-day pathway - suspected cancer patients continue to wait in excess of the 62 days for their first definitive treatment associated with demand in excess of capacity. At the end of November, 23 patients waited in excess of 62 days. Whilst urology continues to have the largest volume of patients waiting over 62 days on the pathway there has been no increase in this trend over the past 3 months
Trust Board Meeting 24th May 2018	12 Performance Report (yearend) Director of Performance and Reform • Performance Year End Assessment	Performance against the 62-day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. This less favorable performance is associated with the total volume of patients on these pathways which present increased demand on the resources available including red flag out-patient and diagnostic capacity. The two predominant breaching specialties in 2017/2018 were **Urology (46%)** and Breast Surgery (14%) which was reflective of workforce pressures demonstrated throughout 2017/2018. Outpatient assessments: Waits over 52-weeks, for SHSCT specialties, are reported across 13 specialties: Breast Family History; Cardiology; Diabetology; ndocrinology; ENT; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine and **Urology**. All of which have established

		capacity gaps and/or accrued backlogs.
Trust Board Meeting 29th November 2018	Agenda Item 12i. Performance Report Director of Performance and Reform • Corporate Dashboard	Waits on the Cancer Pathway (62-day (D) target) 12 patients waited between D-62 and D-85, and 9 patients waited in excess of D-85 for their first treatment. The majority of those waiting more than 62-days were **urology** (10). The longest waits were in urology and lower gastrointestinal surgery at D-213 and D-195 respectively.
Trust Board Meeting 24th January 2019	Agenda Item 9.i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) as at December 2018 Report Summary Sheet	In patients and Day Cases In-Patient (IP) and Day Case (DC) waits over 52-week at the end of December has increased with 2,662 people waiting across 7 specialty areas – Breast Surgery; ENT; General Surgery; Orthopaedics; Paediatrics; Pain Management; and **Urology**. This increasing trend in waits over 52-weeks continues to be demonstrated Regionally as illustrated in Graph 6 overleaf:
	• Corporate Dashboard	Cancer pathways 62 Days 62 day pathways remain challenged with 20 patients waiting longer than 62-days to commence their first treatment in November. Majority of breaches occurred within **Urology** associated with capacity less than demand. Staff sickness absence; delays in first/review appointments and diagnostic delays have contributed to the breaches experienced across all areas. **Urology** continues to experience difficulties across the Region with an increase in referrals also experienced across the Region

Trust Board Meeting 28th March 2019	Agenda 10i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at February 2019 Report Summary Sheet	Cancer Care Capacity for first assessment (red flag and urgent referrals) has been increased where possible, via non recurrent funding, to meet the increased demand in a number of specialty areas, including breast assessment, general surgery, and gastroenterology and to a smaller extent in urology and respiratory services. The Trust has engaged with HSCB and agreed that urology referrals from patients residing in the Western area should no longer come to the Southern Trust in an attempt to rebalance demand and capacity and improve local waiting times.
Trust Board Meeting 23rd May 2019	Agenda Item 8 Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at April 2019 Report Summary Sheet	Elective Care In-Patient (IP) and Day Case (DC) waits over 52-week largely ontinue to increase in line with regional trends. At the end of March 2019 2,700 people were waiting across 9 specialty areas, for over 1 year (Breast Surgery; Cardiology; ENT; General Surgery; Gynaecology; Orthopaedics; Paediatrics; Pain Management; and **Urology**). Whilst the Average waiting time is 37-weeks, with the 95th percentile wait at 119-weeks (Pain Management) the longest routine wait remains within **Urology** at 269-weeks.
	• Corporate Dashboard	Cancer Pathwasy 62 Days 16 patients waitied longer than 62-days to commence their first treatment in March. The majority of breaches continue to occur within **Urology** and patients

		transferring between Trusts. Reasons for breaches include insufficient capacity for assessment, diagnostics and surgery and complex diagnostic pathways in the context of increasing demand. Of the completed waits on the 62-day pathway in March, the longest wait was a Urology patient of 182 days (this reflects the actual wait in the period and not the chronological time period). During 2018/19, there has been an increase in referrals for the 62-day and 31-day pathways which continues to impact the ability to meet the target.
Trust Board Meeting 28th August 2019	Agenda Item 11.i Performance report Director of Performance and Reform • Corporate Performance Dashboard	Cancer Pathways (62 days) During 2019/2020 as at June 2019, 66 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within **Urology**. Of the completed waits on the 62-day pathway in June, the longest completed wait was a Urology patient at 148 days (this reflects the actual wait in the period and not the chronological time period). Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts as well as complex diagnostic pathways. Since March 2019, referrals on the 62- day and 31-day pathways have increased by +9% which impacts on the ability to meet this target. Work is ongoing to assess the impact of reduced additional activity on the cancer pathway waits. Average regional performance is 54%. The Performance Team are working

		with the Acute Cancer Performance Group to explore more detailed analysis of capacity and demand.
Trust Board 30th January 2020	Agenda Item 8 Performance Committee Committee Chair report	b) Elective Care Key Issues demand, capacity, workforce and unscheduled care pressures and growing waiting lists/waiting times. Red flag and urgent priorities, competing pressures for diagnostics. Concerns re reviews beyond clinically indicated timescales Funding –short term nature non – recurrent funding Focus of discussion was on **Urology** and Endoscopy.
Performance Committee 3rd September 2020	Director Performance and Reform • Corporate Performance Scorecard	"Mrs Magwood stated that the Trust has received in-year investment for the 7th **Urology** Consultant. Recruitment is currently ongoing and it is anticipated that the 7th Consultant will be in post in quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and urgent cases with little anticipated impact on routine waits".
Trust Board 22nd October 2020	Agenda Item 13i Performance Committee Committee Chair Report • Mrs. Pauline Lesson	In-Patient/Day Case waits and Planned Repeat Treatments – - increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment. The Trust has received in-year investment of £200,000 for the **Urology** 7th Consultant. Recruitment is currently ongoing and it is

		anticipated that the 7th Consultant will be in post in Quarter 4. The additional capacity created by this post will be targeted to the red flags and urgent with little anticipated impact on routine waits.

Urology mentions within Corporate Risk Register – during my tenure	
May 2020 Page 51 August 2020 Page 50	Clinical teams worked closely with regional Clinical Reference Groups to ensure consistent approach to cancer work across tumor sites
May 2022 Page 6	Review options of attracting temporary consultants without CCT into Consultant roles with support from Trust to obtain GMC certification (radiology/urology)

26.2 I do not recall, across my tenure, being informed of any Urology Concerns unrelated to Mr O'Brien outside of the formal Board and Committee meetings. *Please see:*

134a. Item 9i a. Performance Summary PagePerformanceReport_TB_Final
134b. Item 9i b. Copy of 20171201_CorporateDashboard(OctoberforNovember)TB_Amendment at TB 301117
134c. Item 12i a. PerformanceReport Summary Template_TB_V1_0_AMagwood-LLeeman
134d. Performance Year End Assessment - Item 11i a. TBSummaryPagePerformanceReport_TB_V1_0_LLeeman-LLappin
134e. Item 12ib. 20181122_CorporateDashboard(OctoberforNovember)_TB_V1_0_CRafferty-LLappin
134f. Item 9ia. 20190118_TBSummaryPerformance(DecemberPosition)TB_Report_Final

probably because it was sort of an informal briefing, it was probably the first thing to go in her diary if it was under pressure. I don't know that maybe the understanding was there of the importance of that.

10:46

Around the same time I remember being shown one of the non-executive directors came on a visit to pharmacy at the point she was getting ready to take over the chairmanship of the corporate governance. At that stage I would have attended corporate governance in my 10:47
Director of Pharmacy role. The first item of the agenda was to present the Medicines Governance report, which was a report of my work and the team and my accountable officer's role, and then I left corporate governance, I wouldn't have been present for the rest 10:47
of the meeting. But at that time Mrs. Mullan asked me during that visit would I mind --

65 Q. Mrs. Eileen Mullan?

A. Eileen Mullan. That she would like me to attend the full meeting from then on. I was then after that 10:47
actually able to assist Esther at that meeting with Acute Governance, even though I was there for pharmacy, because I was sort of involved still. If a question came up around the governance issues for Acute, I was able to assist Esther in terms of answering it. 10:47
Obviously I wasn't there at the other meetings like Trust Board and SMT and so on.

66 Q. Yes. Mrs. Gishkori, in her evidence - and her evidence is part-heard - she said a number of things around this

appropriate level and fed into the Board where appropriate. I was satisfied with the performance toolkits in place and training made available that all members of the Board, the various sub-committees, and SMT were aware of when a concern or risk should be escalated to the Board.
During my last few years as Chair we introduced a separate Sub Committee of the Board a - Performance Committee to assess and measure the performance of the services within the Trust and ensure that any performance issues were brought to the attention of the Board.

This new Sub Committee was developed to allow longer time to do a deeper dive into performance and the reports. This was Chaired by an NED and allowed more time to scrutinise the reports and where performance fell short. I expected the CX to always inform me of any serious concerns even outside of the Board scheduling of meetings. I was a visible Chair and always available to be informed.

The Risk Register, SAIs and reports from the CX and SMT members was paramount – I nor any NED would not know what was happening operationally on a day-to-day basis unless the CX and SMT informed us. This was constantly stressed the importance of keeping the NEDs and myself informed. All the Chief Executives that I had worked with, on many occasions would have phoned me to inform of serious adverse incidents and serious clinical issues but I never recall any phone calls or informal meetings to inform me of serious clinical issues in Urology, other than what is recorded in my statement. As Chair of the Board, I was not aware of the detailed information that is now before the USI in relation to clinical issues with Mr O'Brien. (As I refer later, I did not see the detailed Medical Directors report on Mr O'Brien clinical issues that came to the Trust Board in Sept 2020).

As Chair I depended on the CX and SMT informing Trust Board of all clinical concerns via their reports. The Whistleblowing policy was critically important too to ensure that an open and honest culture - modelled from the Board room – was in place throughout the Trust.

personally and had been a former patient of his. The conversation only lasted a few minutes, and I do not remember any detail of clinical issues being told of. Dr Wright assured me that a thorough investigation had commenced. This investigation was confirmed by Dr Wright and the Director of Human Resources at the Confidential Section of the Board 27 January 2017, agenda item 6 (Exhibit RB-01).

Urology services

22. Save for concerns in relation to Mr. O'Brien (which are addressed in questions below), please detail all concerns and issues brought to your attention and the Board's attention (if different) regarding the provision of urology services during your tenure. You should include all relevant details, including dates, names of informants, personnel involved, and a description of the issues and concerns raised. Please also include all documents relevant to your answer.

Urology reporting was part of the Performance Committee and detailed performance reports came to the Board monthly. It was noted each time the long waiting lists in Urology and the Director of Performance had regular meetings with the HSCB regarding the challenges in Urology and the high demands. We had some other specialised areas that had areas of concerns in performance.

The CX and the Director of Performance assured us that these were brought to the attention of the HSCB and Regional direction for Urology was in the planning. My recollection was that a NI Regional review of Urology was taking place due to the high demand in all other Trust areas.

No other Medical Director, Director of Acute Services, Head of Service or Assistant Director ever spoke to me about issues with Urology or Mr O'Brien in particular.

23. Please set out in full what, if anything, was done to address the concerns raised.

The CX and the Director of Performance assured the Board that these had been brought to the attention of the HSCB and that Regional direction for Urology was in planning. I was

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 14 of 2023
Date of Notice: 6th July 2023

Witness Statement of: Pauline Leeson

I, Pauline Leeson, will say as follows:-

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:

(i) an explanation of your role, responsibilities and duties within the Southern Health and Social Care Trust ("the Trust"), and

(ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

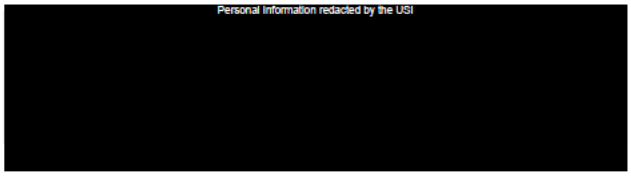
It would greatly assist the inquiry if you would provide the above narrative in numbered paragraphs and in chronological order.

1.1 I have been a Non-Executive Director (NED) with the Trust since January 2017. This is a public appointment. NEDs are responsible to the Minister through the Permanent Secretary of the Department of Health. NEDs are appointed to bring an independent judgement to bear on issues of strategy, performance, and executive appointments within the Trust. The role is to share the independent Non Executive oversight, scrutiny and stewardship of the Trust's work; to hold Executive Directors to account; including assessing the performance of and appointing senior management; to sit on Committees such as Governance and Audit; to participate in professional conduct and competency enquiries as well as staff disciplinary appeals; to scrutinise decision making on major procurement issues and to scrutinise the handling of complaints. It is a time commitment of 1 day a week. I have been a qualified social worker for 40 years and held a number of senior positions mostly in voluntary organisations but not in the Southern Trust. I worked in the Belfast Trust for 6 years from 1987 – 1993. As a NED, I sit on the Trust Board, the Governance Committee and I have chaired the Performance

Urology Services Inquiry

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

Statement of Truth

Signed: 

Dated: 16 August 2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 14 of 2023
Date of Notice: 5th July 2022

Addendum Witness Statement of: Pauline Leeson

I, Pauline Leeson, will say as follows:-

I wish to make the following amendments and additions to my existing Section 21 response dated 16th August 2023, namely:

1. At paragraph 1.4 (WIT-99772), I have stated *'I thought that this was inappropriate as it was a HR matter.'* This should state *'I thought that* ***the letter sent from Mr O'Brien that was circulated to all NEDs (WIT-100340-100347****) was inappropriate as it was a HR matter.* ***I thought that it was inappropriate for Mr O'Brien to send this letter to Mrs Brownlee and for Mr O'Brien to ask that the contents of the letter be brought to the attention of the NED's. I also thought it was inappropriate for this letter to be sent to the NED's.'***

2. At paragraph 9.1 (WIT-99778), I have stated *'I chair the Performance Committee which provides oversight of the Trust's performance management framework and escalates any issues of concern, for example, Cardiology Services in May 2022 and Stroke Services in March 2022 to the Chair and the Chief Executive (minutes attached).*' This should state '*I chair the Performance Committee which provides oversight of the Trust's performance management framework and escalates any issues of concern, for example, Cardiology Services in* ***December*** *2022 and Stroke Services in March 2022 to the Chair and the Chief Executive (minutes attached).*'

3. At paragraph 19.1 (WIT-99786), I have stated '*There does not appear to me, as a NED, to be clear policies and procedures for escalating concerns around governance issues to the Board as a matter of urgency which is why I e mailed the Chair and Chief*

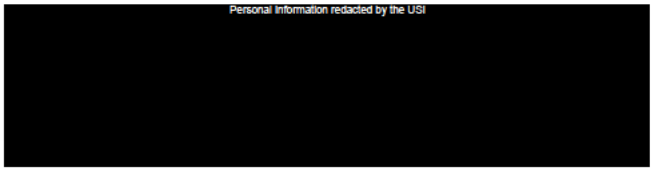
Urology Services Inquiry

x. 30.15
xi. 31.1
xii. 31.2
xiii. 31.3
xiv. 31.4
xv. 31.5
xvi. 31.6
xvii. 31.7
xviii. 31.8
xix. 31.9
xx. 31.10

7. In relation to my response to question 30, my comments can be found in the course of the extract from Ms Roberta Brownlee at paragraphs 30.3, 30.5, 30.7, 30.9 and 30.12. My response to question 31 commences at paragraph 31.11 and runs to 31.17.

Statement of Truth

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

Signed: 

Date: 21st December 2023

Committee since September 2020. As a NED on Trust Board, I am responsible for advising on Strategic Plans which set out the direction of work in the Trust over 3 year periods and providing challenge and scrutiny on reports to the Board from the separate Directorates, primarily through Trust Board and Governance Committee. Trust Board meets bi-monthly. As a NED on the Governance Committee, my role is to ensure that there are effective and regularly reviewed structures in place to support effective implementation and continued development of integrated governance across the Trust; to ensure that principal risks and significant gaps in controls and assurances are considered through reports and escalated to the Board where appropriate using information such as Adverse Incidents, Clinical Audit, Clinical and Social Care Governance systems, Complaints, Standards and Litigation. As Chair of the Performance Committee, I am responsible for providing oversight of the Trusts Performance Management Framework to support continued development of integrated performance across the Trust; to ensure there is sufficient independent and objective assurance as to the robustness of key processes across all areas of performance; to identify risks and gaps in control and assurance and to seek assurance that risks are mitigated and being managed effectively; to review the monitoring information in relation to the performance of the Trust; to ensure timely reports are made to the Trust, including recommendations and remedial action taken or proposed with timeframes, if there is an internal failing in systems or services. The Committees meet quarterly. I was not provided with a job description as a NED. I took part in a NED Induction programme from 9th January 2017 – 30th August 2017. As Chair of the Performance Committee I am responsible for escalating issues to the Trust Board via the Chief Executive and the Chair as referenced in my answer to Q.9. I am not responsible for operational management of day to day activities in the Trust. The Trust has a Chief Executive who is also the Accounting Officer and who is responsible for operational management with the Senior Leadership Team (SLT) which is comprised of Chief Executive, Deputy Chief Executives, Medical Director and Directors of all the Directorates including HR, Nursing, Social Work, Mental Health , Finance, Older people, Performance.

1.2 Mrs Toal, Director of Human Resources and Organisational Development, advised the Trust Board at a Confidential meeting on 27th January 2017 under the MHPS framework that one Consultant Urologist had been immediately excluded from practice from 30th December 2016 for a 4 week period. She said that the immediate exclusion had now been lifted and that the Consultant was able to return to work with a number of controls in place. We were not told what the controls were and no one on Trust Board asked what they were. The Trust Board was not advised of what the controls were. Dr Wright, Medical Director, told the Trust Board that Dr Khan had been appointed as

Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

2.1 I have included a hand written note recording a phone call from Mrs Brownlee asking me to chair the item on Urology at the Trust Board meeting on 24th September 2020. This phone call was in late August/early September 2020. She declared a Conflict of Interest as a former patient of Mr O Brien. She did not declare any other Conflict of Interest. She asked me to raise issues of concern not being brought to Trust Board before. I have also included my hand written notes of my preparation for the item on Urology in the Trust Board meeting on 24th September 2020 where I have highlighted salient points as I understood them in the report plus questions that I considered appropriate to ask in terms of challenge and scrutiny. *Please see:*

6. September 2020 Handwritten Note of Phone Call with RB
7. September 2020 Handwritten Prep Notes to Chair Item re Urology

3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

<u>Training</u>
4. Who was responsible for (i) identifying, and (ii) organising training for Board members?

4.1 Sandra Judt, Board Assurance Manager identified the training.

4.2 Jennifer Comac, PA to Chair organised the training.

5. What, if any, training did Board members receive during your tenure? Please provide all dates and an outline of the purpose and nature of the training received.

5.1 I received Induction training as a NED alongside new NEDs – Geraldine Donaghy and Martin McDonald- from 9th January 2017 to 30th January 2017. This included the role of Trust Board delivered by Mrs Brownlee and Sandra Judt, Board Assurance Manager; Understanding the Organisation delivered

Southern Health and Social Care Trust

Quality Care - for you, with you

Induction Programme for New Board Members

Non-Executive Directors – January 2017

The induction programme set out below will be delivered via a combination of structured presentation, meetings, site visits, directed reading and e-learning.

Topic	Proposed date(s)	Venue	Who to deliver
Initial meeting with the Chair - Welcome and introduction - Induction programme - Leadership Walks - Children's Homes visits - NED meetings - Committee Chair feedback meetings - Attendance at events on behalf of the Chair - Excellence Awards - Outline of appraisal/review process - Training needs analysis – skills, experience and learning needs - Buddy system	9th January 2017 at 12.30 p.m. **COMPLETED**	Chair's Office, Trust HQ	Mrs Roberta Brownlee, Chair
General Information - Travel claims –instructions for completion & authorisation - Photographic ID - Name Badges (on order) - Key contacts			- Mrs Roberta Brownlee, Chair - Mrs Jennifer Comac, PA to the Chair

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
Trust Board - Welcome and introduction. ➢ Accountability lines ➢ Who we are – Trust Board membership; roles and responsibilities to include the role of the Board, Chair; Chief Executive; individual Board members ➢ Committee Structure - Governance Committee, Audit Committee; Remuneration Committee, Endowments and Gifts Committee and Patient and Client Experience Committee ➢ What we do ➢ How we do it – frequency and format of meetings; schedule of reporting to Trust Board - What is expected from a SHSCT Board Member and practicalities of being a Board Member ➢ Board Etiquette ➢ Expectations at meetings and contribution ➢ Induction Pack ➢ Good Governance – Key Governance Documents ➢ Standing Orders and Scheme of Delegation ➢ Standing Financial Instructions ➢ Codes of Conduct and Accountability ➢ Declaration of Interest forms ➢ Gifts and Hospitality	9th January 2017 at 1.30 p.m. **COMPLETED**	Chair's office, Trust HQ	- Mrs Roberta Brownlee, Chair - Mrs Sandra Judt, Board Assurance Manager

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
Administrative arrangements ➢ Trust Board agenda ➢ Distribution of papers ➢ MinutePad ➢ I.T. **Initial meeting with the Chief Executive**	9th January 2017 at 2.00 p.m. **COMPLETED**		
Understanding the organisation - Introduction to the Trust (context, overview, vision, values, objectives, structure) - Role of the Chief Executive - SMT and Directorate structure - Strategic Plan - Key issues	Workshop on 23 February 2017 **COMPLETED**	Boardroom Trust HQ	- Mr Francis Rice, Interim Chief Executive
Meet the Board – Introduction to Directorates	Workshop on 23 February 2017 **COMPLETED**	Boardroom Trust HQ	Each Director as appropriate.

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
- Information sessions with each Directorate. To also include site visits where applicable.	Medical Directorate – 10th March 2017 9.30 a.m. **COMPLETED** Performance and Reform – 27th March 2017 12 noon **COMPLETED** CYPS – 13th April 2017 1 p.m. **COMPLETED** Acute Services – Initial session 2nd May 2017 @ 2 pm – wasn't completed as per previous years so rescheduled for 29th August 2017 @ 2 pm **COMPLETED** MH&LD – 2nd May 2017 11 a.m. **COMPLETED**	Zest, Bannvale Boardroom Trust HQ Meeting Room, Edenderry House Meeting Room, Admin Floor, CAH Boardroom Trust HQ Boardroom Bannvale House	Each Director as appropriate.

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
	Finance Directorate – 29th August 2017 @ 11.45 a.m. **COMPLETED**	Boardroom Trust HQ	
	OPPC – 23rd June 2017 @ 9 a.m. **COMPLETED**	Boardroom Trust HQ	
	Human Resources – 21st September 2017 2 p.m.	Boardroom Trust HQ	
i) Chair/Chief Executive's Office	4th May 2017 **COMPLETED**	Boardroom Trust HQ	Mrs Ruth Rogers and Mrs Jane McKimm, Head of Communications
ii) MinutePad training	9th February 2017 2.30 p.m. **COMPLETED**		Team Solutionz
Meet with Committee Chairs	Prior to each Committee meeting	Trust HQ	
- Role of Audit Committee ➢ Audit Committee Induction	9th February 2017 9.15 a.m. – 10.15 a.m. **COMPLETED**		- Mrs Hilary McCartan, Chair, Audit Committee

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
- Role of Governance Committee	2nd February 2017 9.00 a.m. – 10.00 a.m. **COMPLETED**		- Ms Eileen Mullan, Chair, Governance Committee
- Role of Endowments and Gifts Committee	27th March 2017 9.15 a.m. – 10.15 a.m. **COMPLETED**		- Mrs Siobhan Rooney, Chair, Endowments & Gifts Committee
- Role of Patient and Client Experience Committee	9th March 2017 9.15 a.m. – 10.15 a.m. **COMPLETED**		- Mr John Wilkinson, Chair, Patient and Client Experience Committee
On Board Training (Attendance within 3 months of appointment).	3rd March 2017 **COMPLETED**	Belfast	External provider. (OnBoard Training - David Nicholl)
Learning and Development (Corporate) Corporate Induction Training i) Mandatory Training ii) Key Policy and Procedures iii) Information Governance/E-learning	To be incorporated into HR Directorate Information Session on 21st September 2017		HR Directorate

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
iv) Recruitment and Selection v) Maintaining High Professional Standards	R&S and MHPS Training scheduled for 30th August 2017 **COMPLETED**		Iain Gough, HR (R&S Training) June Turkington, DLS (MHPS Training)
Senior Information Risk Owner training	23rd January 2017 at 11.00 a.m. – 12.00 noon **COMPLETED**		
HMFA e-learning			
Informal Review with Trust Chair	3 months following appointment (Completed as part of Performance Assessment Meeting): Martin McDonald 9/5/17 **COMPLETED**		- Mrs Roberta Brownlee, Trust Chair

RB/sj January 2017

Topic	Proposed date(s)	Venue	Who to deliver
	Geraldine Donaghy 11/5/17 **COMPLETED** Pauline Leeson 22/5/17 **COMPLETED**		

If there are any areas that members feel would be useful additions to the programme, they can also be added

RB/sj January 2017

Training Record

Pauline Leeson	Maintaining High Professional Standards (MHPS)	30th August 2017
	Recruitment and Selection (due 3 yearly)	30th August 2017; 29th June 2021 (virtual with Edel Quinn, HR)
	Fire Safety	Completed by E-Learning November 2017
	Safeguarding Children and Vulnerable Adults	Completed by E-Learning November 2017
	Information Governance	Completed by E-Learning November 2017
	NED Development Session (NICON)	17th April 2018
	Understanding Medical Data – Workshop for NED's (NICON)	24th May 2018
	Infection Prevention Control (expire 20/1/2022)	Completed by E-Learning 21 January 2020
	Equality, Good Relations and Human Rights (expires 20/1/2023)	Completed by E-Learning 21 January 2020
	Fire Awareness (expires 20/1/2021)	Completed by E-Learning 21 January 2020
	Moving and Handling (expires 20/1/2023)	Completed by E-Learning 21 January 2020
	Regional Training Session for NEDs re MHPS – June Turkington DLS	1st December 2021

by Interim Chief Executive, Francis Rice; an introduction to each Directorate by the individual Directors; role of Committees delivered by Committee Chairs (responsible NEDs). MHPS training did not take place until 30th August 2017. I do not feel that MHPS equipped me to fulfil my role as a NED in the process. This continued to be an issue for the NEDs. Training delivered by Esther Gishkori, Director of Acute Services was poor. NEDs were brought to one of her staff meetings in Craigavon Hospital to observe. I complained to the Chair that this was not induction so a second Induction meeting was organised which Mrs Gishkori attended with one of her Assistant Directors. I continue to complete a number of mandatory e learning courses such as Fire Safety, Information Governance, Infection Control and Safeguarding as required. *Please see:*

8. January 2017 NED Induction Programme
9. Training Record - Pauline Leeson

6. Do you consider that the training provided to (i) you and (ii) other Board members was adequate in enabling you to properly fulfill your roles? Please explain your answer by way of examples, as appropriate.

6.1 NED induction training was basic. It included training on MHPS in August 2017. I felt that the training did not sufficiently inform or support me to fulfil the role as a non-medical person. After informal discussion led by John Wilkinson, NED, who had an ongoing complex case, we requested additional training which was delivered in December 2021. I still find the role of the NED in the MHPS process confusing and vague even though I have participated as a NED in 3 straightforward MHPS cases. My understanding is that the NED role is to ensure that the MHPS process is staying to a timeline and is not an advocacy role for the clinicians involved but it is unclear if it is a clinical process or a HR process. I also think myself and other NEDS would have benefitted from more training on Serious Adverse Incidents (SAIs). The Senior Leadership Team received training on SAI Framework in November 2019. *(please see (TRU 21459 – 21486*). The paper was circulated to NEDs in a Governance meeting for discussion on 13th February 2020 but we would have benefitted more from training in terms of understanding the process and what NEDs should be looking for when SAI reports come to the Governance Committee for scrutiny. However, it has only been since Dr O Kane became Medical Director and thereafter that information on MHPS has been collated and presented to the Governance Committee in a systematic way to improve learning. These reports outline the issue, what NED is involved, who is the clinical Investigator, the timescale and the outcome. It enables us to see trends/patterns and if there is delay.

Maintaining High Professional Standards in the Modern HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

Department of Health, Social Services & Public Safety
November 2005

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

Toal, Vivienne

From: Toal, Vivienne [redacted]
Sent: 15 March 2018 13:52
To: Parks, Zoe; 'Hynes, Liz' [redacted]
Cc: Walker, Helen; Hynds, Siobhan; Mallagh-Cassells, Heather
Subject: Re: Review of Maintaining High Professional Standards Policy.

Liz

Can I also add to this that I have some difficulty with the role of the NED in MHPS cases - the document is not clear and at times we have got completely muddled as to what their role actually is and how far they can go when contacted by a doctor going through a process. I think this needs explored as part of any review.

Vivienne

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: "Parks, Zoe" [redacted]
Date: 15/03/2018 13:24 (GMT+00:00)
To: "'Hynes, Liz' [redacted] " [redacted]
Cc: "Walker, Helen" [redacted] "Toal, Vivienne" [redacted], "Hynds, Siobhan" [redacted], "Mallagh-Cassells, Heather" [redacted]
Subject: Review of Maintaining High Professional Standards Policy.

Liz,

Please find attached some comments from the Southern Trust. Please do not hesitate to contact me if you have any queries.

Many thanks

Zoë

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust
[redacted]
My working days are Tuesday-Friday

[redacted] (Internal: [redacted] if dialling from legacy telephone)
Blackberry [redacted]

You can follow us on:

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Training Plan

Maintaining High Professional Standards (MHPS)

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

5.0 Training Plan – Trust Board Training – MHPS

Training Name	MHPS Procedures for full Trust Board
Refresh required	Every 4 years (as per NED Term)
Externals Involved	DLS – Legal Adviser with Trust support
Duration	1 Half Day
Date and Time	This training will be arranged as required and communicated to Trust Board
Logistics Required	Online or Face to Face. Records of Training Attendance to be recorded by facilitator and returned to Medical HR
Room Arrangements	Computer and Wi-Fi access

Training Objectives: By the end of course, delegates will:
▪ Have an understanding of the Maintaining High Professional Standards Framework and the Trust Guidelines 2022
▪ Understand the Informal & Formal procedures outlined with MHPS and Trust Guidelines 2022
▪ Know how MHPS interfaces with appraisal & revalidation, NHS Resolution/PPA, Remedial Action/Back on Track
▪ Gain an overview of how risk and patient safety is managed under MHPS Framework
▪ Be clear on expectations of role and responsibilities as Chief Executive, Medical Director, Director of HR, Designated Board member and /or Panel member within MHPS
▪ Know the specific arrangements that apply when a formal exclusion is implemented
▪ Gain an overview of the legal challenges that can result from MHPS cases
▪ Be clear on MHPS reporting to governance committee

For example, in a meeting on 7th June 2021, NEDs raised the need for staff management, performance appraisals and rotation of staff to be addressed in light of Whistleblowing investigations. *Please see (TRU 22134 – 22158) and:*

10. 20220922 - Corporate Risk Register
11. 20210607 Notes of Chief Executive meeting with Non-Executive Directors

9. Please explain your specific role as Non-Executive Director in assuring yourself and the Board that the clinical governance systems in place are adequate.

9.1 I provide external challenge as a NED to all Directors particularly at Trust Board and Governance Committee. The Governance Committee is key to assessing assurance for effective risk management and escalating risks to the Trust Board. Directors will present reports on specific areas such as Medicines Governance, Mortality and Raising Concerns to enable NEDs to ask questions. There are pre-set agreed standing items like the Corporate Risk Register, Information Governance, etc which come to the Governance Committee as a matter of routine and there are other reports such as Internal Audit which come to the Governance Committee from the Audit Committee to give extra assurance regarding patient safety and risk. There is a report on Clinical and Social Care Governance (CSCG) presented by the Medical Director for scrutiny by the Committee members which identifies risks and what recommendations or remedial action is being taken or proposed to mitigate. This report includes information on key Trust Clinical and Social Care Governance Performance Indicators on Incident Reporting, SAIs, and Catastrophic Incidents, Patient Safety and Quality measures, Service user feedback and Ombudsman cases. The role of the NED is to provide independent scrutiny on the risks and the actions to remedy alongside Executive Directors. I chair the Performance Committee which provides oversight of the Trust's performance management framework and escalates any issues of concern, for example, Cardiology Services in May 2022 and Stroke Services in March 2022 to the Chair and the Chief Executive (minutes attached). One example of how I ensure the clinical governance systems are adequate is when I escalated my concerns as Chair both formally in the minutes of the Committee and more immediately by e mail on the same day in relation to both Cardiology and Stroke Services. In Cardiology services, we needed to reinstate Cath Lab and protect beds in Craigavon in order to treat more patients. In Stroke services, we needed to improve access to Stoke services in Daisy Hill but required more consultants to provide the service. It is important to interrogate the data to understand the issues and then look at an action plan to remedy them. The issue in Cardiology services was as a

13. EXTERNAL ASSURANCE – CARDIOLOGY SERVICES

The Chair welcomed Dr David McEneaney, Consultant Cardiologist and Mrs Kay Carroll, Head of Service for Cardiology to present information on the Cardiology Service within the Trust. The National Cardiac Audit Programme - Myocardial Ischaemia National Project (MINAP) summary report which focused on 2020/21 data was included in members' papers. Members noted that MINAP (Myocardial Ischaemia National Audit Project) is a domain within NICOR (National Institute for Cardiovascular Outcomes Research) that collects data and produces analysis to enable hospitals and health care improvement bodies to monitor and improve the quality of care and outcomes of cardiovascular patients. All hospitals in Northern Ireland contribute to the MINAP national Audit and the Southern Trust participates and utilises information from MINAP to inform the Trusts Cardiology Governance team and the Regional Cardiology Network.

Mrs Carroll began by explaining that the Trust has 32 dedicated Cardiology beds on the CAH site and 6 Cardiology beds on the DHH site. There is a dedicated Cardiac Catherisation laboratory which is operational Monday to Friday 7.30am to 9pm. The Cardiology Service also has a dedicated Cardiac Investigation Department across both acute sites which operates Monday to Friday 8.30am – 5pm service plus Saturday and Sunday ECHO service only on CAH site. Mrs Carroll spoke on the role of the Rapid Access Chest Pain Nurse in the Emergency Department. She advised that the nurse has the skills and knowledge to make decisions to discharge patient's home with no further investigation or discharge with investigations as an outpatient. Mrs Carroll was pleased to report that the Chest Pain Nurse won the Northern Health Care Award for this work in 2021.

Mrs Carroll explained to members the pathways for patients with different diagnosis. Those patients with NSTEMI, their care will be based on NICE guidelines and added to the Regional Cardiology Whiteboard and if accepted for an inpatient procedure the MINAP nurse will monitor the care provided.

Mrs Carroll noted her concern that the Trust does not have protected beds for cardiology patients. She stated that this can lead to patients

Stinson, Emma M

From: Leeson, Pauline
Sent: 05 December 2022 11:39
To: Mullan, Eileen; OKane, Maria
Cc: McDonald, Martin; McCartan, Hilary; Donaghy, Geraldine; Wilkinson, John; Leeman, Lesley; Judt, Sandra
Attachments: Cardiology discussion at Performance Committee meeting on 1st December 2022.docx

Eileen/Maria. Please find attached a record of discussion at Performance Committee on Thursday 1st December. I agreed to escalate the main issue of the need for protected beds and a second Cardiac Cath lab to you for more urgent consideration with the full support of the committee. We did commend the high standard of care that is presently provided and note that Lesley and Catherine are working closely with Dr David McEneaney and Kay Carroll on a business case. Martin has suggested that this issue also goes to Governance with an Improvement Plan. Pauline

Comac, Jennifer

From: Mullan, Eileen [redacted]
Sent: 23 May 2022 11:04
To: Leeson, Pauline
Cc: OKane, Maria; chiefexecutiveoffice; Comac, Jennifer
Subject: RE: Stroke Services - Sentinel Stroke National Audit (SSNAP)

Pauline

By way of update on the below. Maria is taking a lead in reviewing and agreeing a way forward with SMT.

I will add this to the CEO/NED meeting scheduled for June for Maria to update.

Eileen

Eileen Mullan
Southern Trust Board Chair

From: Leeson, Pauline [redacted]
Sent: 11 March 2022 16:15
To: Mullan, Eileen [redacted] McDonald, Martin [redacted] >; Donaghy, Geraldine [redacted] McCartan, Hilary [redacted] Wilkinson, John [redacted]
Cc: OKane, Maria [redacted]; McClements, Melanie [redacted]
Subject: Stroke Services - Sentinel Stroke National Audit (SSNAP)

Eileen. We had a presentation from Dr McCormick at Performance Committee yesterday on SSNAP and I wanted to raise my deepest concern at what we heard. Dr McCormick came to Governance Committee in 2019 when there were plans for a regional strategy, restructuring and investment. I would encourage everyone to read his presentation. Despite the deep professional and personal commitment of him and his team, there is now a marked deterioration in the service. It will be detailed in Committee report and my Chair's report. It appears that he has done everything that was expected of him in terms of reconfiguring services at CAH and DHH but the SSNAP quarterly audit performance in CAH in particular is far below what I would deem as acceptable. Nursing, therapy and rehab goals are also all below recommended guidelines. I understand that his staff were redeployed to ICT during the pandemic and there have also been pressures on AHPs but the deterioration in this service is unacceptable. My overwhelming feeling was of a dedicated clinician and his team who had been quietly working away trying to do their best with little support from us as a Trust. Melanie McClements has picked this up and drawn up an action plan which is very helpful. She has even put in posts at risk to help. I feel strongly that we should be keeping a close eye on this service and on Dr McCormick and his team, giving Stroke Services more priority as part of Rebuild, actively looking for investment and providing support to staff who are at risk , in my opinion, of burnout. We have a duty of care to our staff and an obligation to maintain and improve services for our population. This concern is not a reflection on any of our staff but I would want an assurance going forward that this service and its action plan is prioritised and I have requested that it comes back to Performance Committee in 9 months for an update. Happy to discuss further. I don't think that it would be helpful to bounce this issue around other committees or Trust Board. It seems clear enough that we need to implement Melanie's action plan and reassure Dr McCormick that we care as part of our Trust values. Pauline

17.1 The Chief Executive and Directors in SLT provided information on governance issues both to the Governance Committee and to Trust Board. Governance issues could be escalated to the Trust Board by the Chair of Governance or the Chief Executive through the Governance Committee. Governance issues can be placed on the Confidential section of Trust Board by the Chair of Governance Committee, the Chief Executive or the Chair of Trust Board. The Chair of the Governance Committee provided a quarterly report to the Chair of Trust Board which included any issues of concern raised in the Governance Committee. The Medical Director is directly responsible for Clinical concerns and can report through the CSCG report in the Governance Committee or bring an issue to Confidential section of Trust Board. If there are serious concerns, they can be raised by Directors or NEDs directly with the Chief Executive and the Chair as I did as Chair of performance by e mail immediately in relation to Cardiology and Stroke concerns. *Please see:*

34. 20210909 FINAL CSCG Report September 2021

18. How was this information recorded and communicated to the Board? How did the Board assure itself of the accuracy and completeness of this information?

18.1 The Governance Committee reports through its Chair to Trust Board. The Chairs of committees are asked to submit quarterly reports summarising areas considered at the committee meetings including areas of concern *(please see 36. Governance Committee_Chair Report 11.05.23)* The Chair's report is a written record of concerns that were raised at the committee meeting. Members of Trust Board can ask questions or raise concerns both formally and informally. All Board members – NEDs and Executive members – ask for assurance that actions recorded in writing on the Matters Arising section of the meetings are completed.

19. What procedures and policies are in place to allow concerns around governance issues to be escalated to the Board as a matter of urgency? Please explain how these procedures and policies work in practice, providing examples, as relevant.

19.1 Early Alerts are in place to allow concerns around issues including governance to be raised urgently. They are primarily used to alert the DOH about significant incidents within 48 hours and can be copied to Trust Board for information. They are sent to the Chair of the Board initially and the Chair makes the decision whether or not they are to be shared with NEDs. I was only copied into Early Alerts as a NED in the period directly before the last

Chair, Mrs Brownlee, ended her time with the Southern Trust. I was not copied into the Early Alert about SAIs raised in relation to Urology at the workshop in August 2020. There does not appear to me, as a NED, to be clear policies and procedures for escalating concerns around governance issues to the Board as a matter of urgency which is why I e mailed the Chair and Chief Executive directly and immediately about issues raised about Cardiology and Stroke services in the Performance Committee in March and May 2022. Whistleblowing concerns can be raised with staff or NEDs through the Whistleblowing policy. This is a process which is handled through HR but I haven't seen this procedure being used to escalate governance issues to Trust Board as a matter of urgency. The Whistleblowing NED action card informs NEDs what to do if they are directly approached by a member of staff about a concern – it has to be referred to official channels through HR and a NED cannot deal with the concern. *Please see (TRU 21050 – 21071) and:*

37. Item 7. NED action card re raising concerns FINAL
38. SHSCT Early Alerts Policy

20. How, if at all, does the Board communicate with the Department regarding issues of patient safety and risk?

20.1 Early Alerts, SAIs, direct communication between the Chair/Chief Executive and the Permanent Secretary in DOH are all methods that I am aware of that the Board uses to communicate with the Department regarding issues of Patient Safety and Risk. I am not involved with these communications as a NED.

21. Are the issues of concern and risk identified in urology services of the type the Board would be expected to have been informed about at an early stage? Was the Board informed of concerns regarding urology, and Mr. O'Brien in particular, at the appropriate time? If not, what should have happened, when, and why did it not?

21.1 The issues of concern and risk identified in urology services are the type that the Board would be expected to have been informed about at an early stage when there is clear evidence of potential patient harm. The Board was first informed about the Consultant in January 2017 which was appropriate as he was referred to MHPS. It was reported verbally briefly at my first meeting as a NED in January 2017 and it was not sufficient to understand what the risks were for patients. I was not aware of the name of the Consultant at this time. That was the first time that I was made aware of concerns about his practice. No issues regarding SAIs were brought to the Board connected to this matter

40.1 Responsible Directors (Executive/Operational) are required to attend Governance Committee Meetings to present on matters within their remit. Papers are expected to be prepared to inform Committee Members to enable discussion to take place at the meeting.

40.2 The Governance Committee has an annual work plan which sets out when items are to be presented to the Committee. Clinical and Social Care Governance is a standing item at each meeting.

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Clinical and Social Care Governance	Clinical and Social Care Governance Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Information
	Management of Trust Standards and Guidelines	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	Mortality Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	National Audit Assurance Report	Medical Director / Assistant Director C&SCG	Annually	November 2023	Assurance

Please see 14. Governance Committee Work Plan 2023.

40.3 In the reporting to the Committee, the data and information provided allows for identification of trends (improvements and decline). Each Director also has the opportunity to raise any concerns they have at any point. An example of this is a concern raised by Dr O'Kane, as Medical Director, to the Committee at its meeting of the 5th December 2019. This resulted in a whistleblowing investigation and the committee being updated at its meetings over the next 2 years (as summarised below).

Meeting	**Detail**
Governance Committee 05th December 2019	Agenda Item 2 Presentation: Obstetrics and Gynaecology

description of the issues and concerns raised. Please also include all documents relevant to your answer.

26.1 During my tenure Urology concerns and issues (other than in respect of Mr O'Brien) brought to my attention and the Board's attention are summarised below:

Meeting	Agenda Item	Detail
Trust Board Meeting 30th November 2017	9 Operational Performance Director of Performance and Reform • OGI Performance Summary at the end of October 2017 (report summary sheet)	Waits on Cancer pathways: 62-days- patient continue to be in excess of the 62-day pathway target, associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper and lower gastro-intestinal (GI) specialties. In September 18 patients breached the 62-day, with the majority within **Urology 44%** (8 out of 18) and the in the Lung; Skin; UGI; Colorectal; and Gynae tumour site.
	• Corporate Dashboard	Cancer Pathway 62 Days (Reported one month in arrears) Performance in 2016/2017 demonstrated a decrease in comparison to 2015/2016 (88.30%) and based on the performance projects this year an improvement is not anticipated. This is associated with an increased level of patients on the pathway with increased demand on the resources available, include red flag out-patient and diagnostic capacity. The percentage of confirmed cancers has not demonstrated a disproportionate increase. The majority of 62-day pathway breaches for the Trust continues to be within **Urology**,

		capacity gaps and/or accrued backlogs.
Trust Board Meeting 29th November 2018	Agenda Item 12i. Performance Report Director of Performance and Reform • Corporate Dashboard	Waits on the Cancer Pathway (62-day (D) target) 12 patients waited between D-62 and D-85, and 9 patients waited in excess of D-85 for their first treatment. The majority of those waiting more than 62-days were **urology** (10). The longest waits were in urology and lower gastrointestinal surgery at D-213 and D-195 respectively.
Trust Board Meeting 24th January 2019	Agenda Item 9.i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) as at December 2018 Report Summary Sheet	In patients and Day Cases In-Patient (IP) and Day Case (DC) waits over 52-week at the end of December has increased with 2,662 people waiting across 7 specialty areas – Breast Surgery; ENT; General Surgery; Orthopaedics; Paediatrics; Pain Management; and **Urology**. This increasing trend in waits over 52-weeks continues to be demonstrated Regionally as illustrated in Graph 6 overleaf:
	• Corporate Dashboard	Cancer pathways 62 Days 62 day pathways remain challenged with 20 patients waiting longer than 62-days to commence their first treatment in November. Majority of breaches occurred within **Urology** associated with capacity less than demand. Staff sickness absence; delays in first/review appointments and diagnostic delays have contributed to the breaches experienced across all areas. **Urology** continues to experience difficulties across the Region with an increase in referrals also experienced across the Region

Trust Board Meeting 28th March 2019	Agenda 10i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at February 2019 Report Summary Sheet	Cancer Care Capacity for first assessment (red flag and urgent referrals) has been increased where possible, via non recurrent funding, to meet the increased demand in a number of specialty areas, including breast assessment, general surgery, and gastroenterology and to a smaller extent in urology and respiratory services. The Trust has engaged with HSCB and agreed that urology referrals from patients residing in the Western area should no longer come to the Southern Trust in an attempt to rebalance demand and capacity and improve local waiting times.
Trust Board Meeting 23rd May 2019	Agenda Item 8 Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at April 2019 Report Summary Sheet	Elective Care In-Patient (IP) and Day Case (DC) waits over 52-week largely ontinue to increase in line with regional trends. At the end of March 2019 2,700 people were waiting across 9 specialty areas, for over 1 year (Breast Surgery; Cardiology; ENT; General Surgery; Gynaecology; Orthopaedics; Paediatrics; Pain Management; and **Urology**). Whilst the Average waiting time is 37-weeks, with the 95th percentile wait at 119-weeks (Pain Management) the longest routine wait remains within **Urology** at 269-weeks.
	• Corporate Dashboard	Cancer Pathwasy 62 Days 16 patients waitied longer than 62-days to commence their first treatment in March. The majority of breaches continue to occur within **Urology** and patients

Southern Health and Social Care Trust

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Clinical and Social Care Governance Report February 2022

1.0 Purpose of Report

This report is to provide information to Trust Governance Committee regarding the Clinical and Social Care Governance performance indicators agreed by the Trust Senior Management Team:

- **Incident monitoring to include Serious Adverse Incident and reporting timeframes**
- **Patient safety & quality measures**
- **Complaint monitoring**
- **Compliment monitoring**

The report analyses activity for the period **1st October – 31st December 2021 (Quarter 3),** with the exception of Patient Safety & Quality measures which are for the previous quarter **1st July – 30th September 2021 (Quarter 2).** Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of recurrence.

To set the wider context, this quarterly reporting period – **01/10/2021 to 31/12/2021 -** reports on Clinical and Social Care Governance performance indicators during the CoronaVirus pandemic period.

The Trust Oversight Group met on 10th November 2021 where a review of progress against objectives was undertaken. Mrs Trouton spoke of the planned audit which was undertaken on 13th September and the full report, audit findings and action plan were included in members' papers.

Training figures were discussed. Mrs Trouton reminded members that at the last meeting it was highlighted that medical training figures included all doctors and the next report will only focus on medical staff that work directly with Children to provide a better overview. She referred members to this data on page 6 of the report which has been broken down to show the training results for each area that a child would have potential to be admitted to. Mrs Trouton reported that overall 52% of Consultants and SAS doctors had completed training, 10% desist and 38% had no status or was invalid.

Mrs Trouton spoke of regional work streams and reminded members that of the 9 regional work streams, 8 were paused from March 2020 with Duty of Candour continuing. The Department of Health are reviewing the recommendations and planning a way forward. A number of meetings have taken place over January 2022 and early indication from the Department is that the work streams associated with SAI, Paediatrics, Preparation for Inquest, Bereavement and Pathology will be recommenced soon.

10. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Dr Gormley presented the above named report, which provides information on SAIs, catastrophic incidents, learning on patient safety initiatives, complaints and ombudsman cases from 1st October 2021 to 31st December 2021, with the exception of Patient Safety & Quality measures, which are for the previous quarter 1st July 2021 to 30th September 2021.

Dr Gormley commented on the areas of improvement which highlighted that the number of incidents reported in this quarter has decreased by 2% since the last quarter and there is a significant

reduction in incidents reported within MHD Directorate this reporting quarter.

Dr Gormley spoke on the number of unapproved incidents on Datix and until these are reviewed and coded, there is a risk that a significant incident has not been addressed and learning applied. He added that the volume of un-coded incidents on Datix makes it difficult to theme and identify trends over time. In response to a question asked by Mr Wilkinson, Dr Gormley explained that unapproved incidents does not mean they haven't been opened, the team are just unable to provide assurance at that point in time. The Chair asked what steps are being taken to address this.

Dr Gormley commented that since the last quarter, all 2016 incidents have been approved, 2017 incidents have been reduced to 6 from 37 and all Directorates submitted an action plan to address these issues. Mr Beattie noted that within OPPC there is a recognised backlog of incidents pertaining largely to the Independent Sector that are awaiting final approval. These have been reviewed and the Directorate has completed a look back exercise to quantify the number, severity, type and operational areas relating to the backlog and identified teams and areas for particular focus. A task and finish group has been established across the Trust to look at the reporting levels and the management of incidents reported by the Independent Care Home sector initially. This group seeks to establish agreed acceptable thresholds for reporting and streamlined processes to enable these to be investigated and finally approved without resorting to a back log situation.

Mrs Leeson referred to incident 141489 on page 17 in relation to staff attitude and asked if this was a trend within IMWH. Dr Gormley noted that information from DATIX, GREATix and Care Opinion would highlight any significant trends in relation to staff attitudes in IMWH. The Chair spoke of the importance of triangulation of data.

Ms Donaghy noted that waiting times now appear within the top 5 complaint subjects due to a change in reporting mechanism. Mrs Doyle explained that previous reporting reviewed individual areas and when combined, waiting times is a significant complaint type. Ms Donaghy asked if it was possible to include both individual and

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								complaints process.
141489	19/06/2021	08/12/2021	02.11.21 PMRT done promptly after delivery. Had been tabled for SJR. Patient requesting feedback around issues- main concerns staff attitude. HOS + consultant meeting patient to discuss. Felt SJR may give quicker response but may not address attitudes. 09/11/21 - Clarify outcome of meeting and what process unresolved questions will be addressed. 16.11.21 - PMRT identified potential miss in early intervention, agreed level 1 SAI	Large fetal maternal hemorrhage and IUD.	Acute Services	Moderate	Yes	CTG monitoring and recognition of abnormal CTG . Staff reminded of policy and procedures for CTG duration, needing an assessment period of 20 minutes as a minimum. Midwifes are required as mandatory training to attend an annual update.
148884	21/10/2021	30/11/2021	21/10/2021 Datix submitted.	Management of unwell urology patient awaiting transfer.	Acute Services	Moderate	Yes	The need for an agreed systemic process for the

Chair, Mrs Brownlee, ended her time with the Southern Trust. I was not copied into the Early Alert about SAIs raised in relation to Urology at the workshop in August 2020. There does not appear to me, as a NED, to be clear policies and procedures for escalating concerns around governance issues to the Board as a matter of urgency which is why I e mailed the Chair and Chief Executive directly and immediately about issues raised about Cardiology and Stroke services in the Performance Committee in March and May 2022. Whistleblowing concerns can be raised with staff or NEDs through the Whistleblowing policy. This is a process which is handled through HR but I haven't seen this procedure being used to escalate governance issues to Trust Board as a matter of urgency. The Whistleblowing NED action card informs NEDs what to do if they are directly approached by a member of staff about a concern – it has to be referred to official channels through HR and a NED cannot deal with the concern. *Please see (TRU 21050 – 21071) and:*

37. Item 7. NED action card re raising concerns FINAL
38. SHSCT Early Alerts Policy

20. How, if at all, does the Board communicate with the Department regarding issues of patient safety and risk?

20.1 Early Alerts, SAIs, direct communication between the Chair/Chief Executive and the Permanent Secretary in DOH are all methods that I am aware of that the Board uses to communicate with the Department regarding issues of Patient Safety and Risk. I am not involved with these communications as a NED.

21. Are the issues of concern and risk identified in urology services of the type the Board would be expected to have been informed about at an early stage? Was the Board informed of concerns regarding urology, and Mr. O'Brien in particular, at the appropriate time? If not, what should have happened, when, and why did it not?

21.1 The issues of concern and risk identified in urology services are the type that the Board would be expected to have been informed about at an early stage when there is clear evidence of potential patient harm. The Board was first informed about the Consultant in January 2017 which was appropriate as he was referred to MHPS. It was reported verbally briefly at my first meeting as a NED in January 2017 and it was not sufficient to understand what the risks were for patients. I was not aware of the name of the Consultant at this time. That was the first time that I was made aware of concerns about his practice. No issues regarding SAIs were brought to the Board connected to this matter

at this meeting. I was told of further concerns in August 2020 in relation to a number of SAIs. A comprehensive report detailing the evidence and timeline was brought to Confidential Trust Board meeting on 24th September 2020. *(Please see 39. 20200924 Trust Board Urology Report).* There had been an ongoing MHPS process which, to my knowledge, was addressing concerns in respect of Mr O'Brien. We were not told what the concerns were in January 2017. We were not given updates regarding the ongoing case or the outcome of this process to Trust Board since January 2017 and no other issues were brought to Trust Board between January 2017 and August 2020. The report brought to the Board in September 2020 was prompted by an e mail from Consultant A – Mr O Brien – in June 2020 which raised potential patient safety concerns about the Consultant's practice and a review of Mr O Brien's work was undertaken. The report detailed a number of ongoing concerns which were being dealt with under the MHPS process which appeared to take a much longer time to complete than other cases under MHPS. The delay in the MHPS should have been flagged and brought to Governance Committee sooner for information and update. Since August 2020, a tighter system of appraisals has been put in place to monitor practice; SAIs, Early Alerts and MHPS all come for information to Governance Committee. These safeguards might have brought these governance issues to the Board's attention if they had been put in place earlier.

Urology services

22. Save for concerns in relation to Mr. O'Brien (which are addressed in questions below), please detail all concerns and issues brought to your attention and the Board's attention (if different) regarding the provision of urology services during your tenure. You should include all relevant details, including dates, names of informants, personnel involved and a description of the issues and concerns raised. Please also include all documents relevant to your answer.

22.1 Mrs Toal advised the Trust Board on 27th January 2017 of an issue in relation to an unnamed Consultant Urologist who had been excluded from practice for a 4 week period.

22.2 There were no concerns regarding Urology brought to the Board between January 2017 and August 2020.

22.3 Dr O Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired urologist on 27th August 2020 at a workshop under Any Other Business. This was the first time that these

24. How, if at all, did the Board monitor and evaluate any decisions or actions taken to address concerns?

24.1 The Trust Board requested updates on actions taken at every Trust Board meeting. These were included as full items on the Trust Board agenda for discussion and scrutiny. Updates on governance concerns in relation to Urology were also provided at NED/Chief Executive meetings so that NEDs were satisfied that actions taken were effective. We monitored decisions/actions taken by the Medical Director, Dr O Kane, through reports, asking questions on progress. Questions were asked about progress of SAIs, liaison with families affected and progress on GMC and Private Practices. *Please see:*

40. Approved Minutes of previous meeting held on 31st March 2022

25. Was it your view and the view of the Board that actions taken were effective? If yes, please explain why. If the actions taken were not effective, explain why, and outline what, if anything, was done subsequently?

25.1 Yes, once the Board was alerted to concerns in relation to SAIs in August 2020, the Board asked for regular updates so that we could monitor progress on actions taken in relation to the concerns about Mr O Brien and his practice. The Trust Board requested and received updates on Urology concerns at each meeting to monitor and scrutinise progress. In my view, I thought the updates gave us as Trust Board greater clarity and assurance that effective actions were being taken in terms of greater involvement of the families affected, the progress of the Look Back review for patients and progress on SAIs.

Mr Aidan O'Brien

26. Please provide full details of when, how and by whom (i) you and (ii) the Board (if different or at different times) were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided or produced? This should include any contact made by or to the Board involving the Trust's management team, including the Chief Executive.

26.1 I was first made aware of issues/concerns in relation to the practice of Mr O'Brien in the Trust Board confidential meeting on 27th January 2017. Concerns were being dealt with under an MHPS process. We were not told of what the concerns were about, what controls were being put in place. There was no mention of any SAIs. Mrs Toal reported that an unnamed Consultant

Southern Health and Social Care Trust
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Minutes of a confidential meeting of Trust Board held on Friday, 27th January 2017 at 10.00 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mr S McNally, Acting 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
Mrs A McVeigh, Director of Older People and Primary Care Services/ Acting Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mr F Rice, Interim Chief Executive

McMurray confirmed that the Trust met with Senior and Junior Counsel on 15th December 2016 and has provided them with information to assist in their preparation of a responding Affidavit. He advised that Mr Gerry McAlinden has been instructed as Senior Counsel and Mr Barry Woods as Junior Counsel for the Trust and both are very experienced in these matters. The Chair asked Mr McMurray if he was satisfied that there was appropriate support for Trust staff to prepare for and during Judicial Review proceedings. Mr McMurray advised that it is senior staff who will be attending and they are well prepared. Additional support has been offered to them, but they do not wish to avail of this at this point.

Mr McMurray updated members on the Nursing and Midwifery Council (NMC) referral relating to one of the Home Owners, who is a registered nurse. The NMC is now taking this forward as case review.

ii) Personal Information redacted

Mr McMurray verbally updated members on the current position. He advised that the gentleman has been transferred to Personal Information redacted by the USI for a period of assessment. There has been no confirmation as to whether the Judicial Review will be heard and he reminded members that this is based on the gentleman's solicitor's view that the Trust is obliged to provide a suitable secure accommodation bail address, which despite significant efforts, the Trust has been unable to secure. The Trust is attempting to procure a bespoke care package which is likely to be at a significant cost.

The Chair left the meeting for the next item.

6. MAINTAINING HIGH PROFESSIONAL STANDARDS (MHPS) EXCLUSIONS

Mrs Toal advised that under the MHPS framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for

a four-week period. Mrs Toal reported that the immediate exclusion has now been lifted and the Consultant is now able to return to work with a number of controls in place.

Dr Wright explained the investigation process. He stated that Dr Khan has been appointed as the Case Manager and Mr C Weir, as Case Investigator. Mr J Wilkinson is the nominated Non Executive Director. Dr Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NCAS have also been advised.

7. WAITING LIST INITIATIVES – RADIOLOGY

The Chair informed members of a letter she had received from the Radiology Department expressing their concern at the Internal Audit review of Waiting List Initiative Payments 2016/17. Dr Wright explained the scope of this assignment which was undertaken by Internal Audit at the request of the Trust to carry out a review of the payments made to the Consultants earning the most from WLI work within the Trust in the period 1st April 2015 to 31st March 2016. This review was set in the context of an initial review by the Trust following a FOI request and media coverage regarding WLI payments that identified the Southern Trust as having the highest WLI earners within Northern Ireland with one Consultant making it into the top 5 UK national list of highest earners.

Members were advised that the IA Report will be discussed at the forthcoming Audit Committee. Dr Wright explained that this has identified issues around the process and there appears to be a degree of confusion between payment for activity and payment for time, resulting in individuals being paid for more than they worked. The Trust has sought legal advice on the recovery of these alleged overpayments and DLS have indicated that to seek recovery would prove far from straightforward. The Department has been made aware of this situation and the Interim Chief Executive has submitted an application to the Department for approval for foregoing recoupment of these overpayments as they exceed the Trust's delegated authority. A response is awaited. Dr Wright stated that to pursue recovery of the overpayments may result in a number of resignations of Radiologists involved resulting in the Trust not being able to deliver on a substantial amount of clinical work. He spoke of the difficulties recruiting into this

From: Judt, Sandra
Sent: 11 June 2020 14:06
To: Rooney, SiobhanNED; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; Mullan, Eileen; McDonald, Martin; Wilkinson, John
Subject: CONFIDENTIAL FROM THE CHAIR: URGENT COMMUNICATION

Please find attached confidential information from the Chair.

Regards

Sandra

Sandra Judt

Board Assurance Manager

SH&SCT

Trust Headquarters

68 Lurgan Road

Portadown

Craigavon

BT63 5QQ

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

From: Brownlee, Roberta
Sent: 11 June 2020 14:01
To: Judt, Sandra
Subject: Fwd: URGENT COMMUNICATION

Sent from my iPad

Mrs Roberta Brownlee,
Chair
Southern Health & Social Care Board
Trust Headquarters
Craigavon Area Hospital
Portadown
BT63 5QQ

10 June 2020

Dear Mrs. Brownlee,

I attach a letter which I sent to Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, last evening, and a letter which I sent to Mr. Shane Devlin, Chief Executive, earlier today.

The point of both letters was to advise that I had submitted, on 06 March 2020, an application for pension benefits to become payable with effect from 30 June 2020, to coincide with an intent to withdraw from full time employment from that date, and with the intent to return to part time employment from 03 August 2020, having received the assurance of support from colleagues and line managers to do so, and without being informed by the Trust of any impediment to my doing so. I was then advised by telephone on Monday 08 June 2020 that I would not be permitted to return to part time employment in August 2020 due to the 'Trust's practice of not re-engaging people with ongoing HR processes'. If I had been informed of this practice by the Trust, I most certainly would not have submitted any notification of intent to withdraw from full time employment.

You will be aware that the ongoing HR processes to which reference has been made are the Formal Investigation (initiated on 30 December 2016 and completed on 01 October 2018) and a Formal Grievance (submitted on 27 November 2018 and not yet addressed). The Formal Grievance included an appeal of the Outcome of the Formal Investigation. That appeal has not been addressed, 20 months later.

I now feel all the more aggrieved by the Trust's claim to have a practice of not re-employing personnel if there are ongoing HR processes, when the Trust has been primarily responsible for the ongoing status of those HR processes, and not having been informed by the Trust, my employer, of that practice. It is important to note that it is the same Directorate which has failed to have my grievance and appeal addressed after 20 months in contravention of its own policy, the same Directorate which has accepted and processed my intent to withdraw from full time employment, and which would have been cognisant of my intent to return to part time employment as that intent is an integral part of the application proforma, and which would have been cognisant of a

Trust practice which would be an impediment to returning to part time employment, and about which I was not informed.

As a consequence, I have had no other option but to revoke my intention to withdraw from full time employment. I have already deferred payment of pension benefits earlier today.

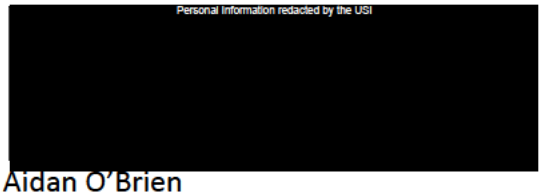
It will have been 28 years ago tomorrow, Thursday 11 June 1992, that I was appointed to the post of Consultant Urologist at Craigavon Area Hospital. From then until 1996, I single-handedly provided a 24 hour service. From 1996, with the assistance of increasing numbers of colleagues, I have endeavoured to contribute to the development of urological services by the Trust. Nevertheless, those services remain severely inadequate. Covid-19 has further exacerbated that inadequacy. By August 2020, there will be patients waiting up to six years for admission for surgery. By then, there will be patients waiting over three years for outpatient consultations following referral, and for review following investigation or management.

Today, Mr. Robin Swann, Health Minister, referring to a framework for rebuilding health and social care services in Northern Ireland, said that 'this strategic approach is about throwing absolutely everything we can at those waiting lists and those missed diagnoses and treatments that were put on pause during the Covid-19 pandemic'. The Minister advised that Northern Ireland has the longest waiting lists in the UK and Ireland. The Southern Trust's longest, surgical waiting lists are urological. Yet, the Trust finds it appropriate to prohibit me from part time employment in the face of such need due to ongoing HR processes for which the Trust has been responsible.

I do appreciate that you, and your non-Executive colleagues, have been appointed to the Trust Board by the Health Minister, and that the Trust is accountable to the Board, on behalf of the Minister, across a number of key areas, including the delivery of health and social care objectives, financial probity and governance. I write to ask you to bring to the attention of your non-Executive colleagues, the contents of this letter, and of those sent to Mr. Devlin and Mrs. Toal. In doing so, I have not made reference to any of the issues subject to the Investigation, or to any content of the Grievance or of the Appeal. I write to inform you and your colleagues of the severity of the lack of the Trust's compliance with its own Policies and Procedures, the severity of the impact of its lack of compliance upon a member of its staff, and the consequential impact upon the delivery of services expected by the Minister.

I hope that you and your non-Executive colleagues may be able to have some bearing in attempting to resolve this ongoing situation. For me, personally and professionally, it is very important that I can continue to work, but with a better work life balance. It is also most important for me that the Formal Grievance and its included Appeal are addressed. I am certainly prepared to work constructively with the Trust to achieve a just and satisfactory resolution, and particularly to the benefit of patients.

Yours sincerely,



Aidan O'Brien

Southern Health and Social Care Trust
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Notes of a Virtual Directors' Workshop held on Thursday, 27th August 2020 at 9.15 a.m.

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
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, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr Brian 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
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 S McCormick, Committee Secretary *(Notes)*

1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies were noted from Mr Martin McDonald, Non-Executive Director. [redacted]
Personal Information redacted by the USI

The Chair left the meeting at this point.

Dr O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the Workshop.

The Chair returned to the meeting at this point.

Dr O'Kane drew member's attention to staffing issues within the Infection Prevention Control (IPC) team along with a significant increase in workload due to Covid-19. She also alerted members to particular medical workforce challenges in the GP Out of Hours Service and Acute Physicians.

The Chair thanked Executive Directors for providing updates on important issues within their areas of responsibility.

7. ANY OTHER BUSINESS

None.

The workshop concluded at 12 noon

and non RRL anticipated income of £42.8m, the Trust has a total maximum income of £760m available and hence the spending allowance for the Trust is currently £760m in 2020/21.

Ms O'Neill reported total forecasted expenditure 2020/21 of £774.3m as detailed in Table 7 of the document, leaving a forecasted gap of £14.3m. She advised that measures of £7m have been identified, these include pharmacy prescribing measures and natural slippage on some full year allocations, leaving at this stage an unresolved gap of a maximum of £7m.

Ms O'Neill stated that the financial plan will be further refined, with the Department of Health planning meetings to take place in September 2020. Directors will continue to review what additional savings measures are possible in the event that additional funding is not secured. Mrs McCartan asked if it was permissible to submit an Interim Financial Strategy without a balanced budget. Ms O'Neill stated that Directors of Finance were asked to submit a plan which identified the impact of the indicative allocations. This is merely the first stage and at present this shows an unresolved gap of £7m. The Interim Financial Strategy being discussed at Trust Board is to seek approval to set an unbalanced budget to support the appropriate stewardship and accountability of public funds. As discussions evolve with both the HSCB and DoH, the position may change, to include either potential additional unplanned expenditure benefits or some further funding support. Mrs McCartan noted the Trust's statutory duty to breakeven and stated that hopefully additional funding support would be secured.

Trust Board approved the setting of an unbalanced interim budget for 2020/21

3. **ANY OTHER BUSINESS**

i) SAI

Dr O'Kane brought to the Board's attention SAI investigations into concerns involving a recently retired Consultant Urologist. Members requested a written update for the next confidential Trust Board meeting.

DOH-00666 to note. ANNEX A

☒ **Initial call made to** CMO OFFICE **(DoH) on** 01.08. 20 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Noted 9/13/21

Details of Person making Notification:

Name: Dr Maria O'Kane | Organisation: Southern Health and Social Care Trust

Position: Medical Director | Telephone: [redacted]

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) [redacted] ; [redacted]

Mobile (work or home) Telephone (work or home [redacted]

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Mrs McCartan welcomed the Interim Financial Strategy and the indicative allocations. She congratulated the Trust on the additional funding support secured.

Trust Board approved the Interim Financial Strategy and the Interim Resource Budget for 2019/20

Finance Report

Ms O'Neill presented the Finance Report for the four months ending 31st July 2019. She stated that the current deficit was £1.3m and, given that this was an agreed interim budget, the overspend expected was c £600k. She explained that two main issues causing the variance were transformation and continued unscheduled care pressures. In response to a question from Mrs McCartan, the Chief Executive advised that further detail on winter plans would be brought to Trust Board with the focus for this year being on ambulatory care.

Ms O'Neill advised that the finance report would continue to be reported to the confidential section of the meeting until the TDP was approved.

7. **INDEPENDENT SAI REVIEW INTO THE CIRCUMSTANCES WHICH RESULTED IN THE DEATH OF** Personal Information redacted by the USI

The Chief Executive advised that the Independent Review Panel has issued their final report which was shared with the Trust and the family in July 2019. Subsequent to the issue of the report, the Personal Information redacted by the USI family met with the Permanent Secretary who issued an unreserved apology on behalf of the HSC and the Chief Executive met with the family the previous week. The Chief Executive referred members to the Executive Summary included in their papers and stated that Trust Board are asked to note the recommendations which are both at a system wide level, and specific to individual Trusts. He further advised that a regional programme of work will be developed to begin to address the recommendations, with appropriate local structures being developed.

The Chief Executive stated that it was important to emphasis the impact on staff involved in this case and support continues to be provided to them. He noted that the Personal Information redacted by the USI family are very involved

Southern Health and Social Care Trust

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Policy for Reporting of Early Alerts to the Department of Health (DoH)

Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social; Care Governance Co-Ordinator Nicole O'Neill, Corporate Clinical and Social Care Governance Manager
Directorate responsible for document:	Medical
Issue Date:	28 July 2022
Review Date:	Click here to enter a date.

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2.7 The Corporate CSCG office will insert the appropriate reference number, anonymise the content and issue to the DoH/SPPG early alerts mailbox within 24 hours of the initial telephone notification at 3.3. At no time should the completed proforma be forwarded to the DoH/SPPG by anyone other than Corporate CSCG Department staff.

2.8 The report will be issued simultaneously by the Corporate CSCG office to the Chief Executive, the Chair, Directors, Non-Executive Directors, the relevant Assistant Director, the Communications Manager, CSCG staff including the Assistant Director for CSCG and any other relevant officers as deemed appropriate by the Corporate CSCG department.

2.9 The SPPG will provide an update and decision on whether the file can be closed or further follow up is required to the Corporate CSCG department Irrelevant information redacted by the USI within 4 weeks of receipt of Early Alert. Details of this update will be shared with CSCG staff within the relevant Directorate. ** Early Alerts in relation to reduced cover within GP Out of Hours will not be followed and an automatic update of "the issue in relation to reduced cover within GP Out of Hours continues, Early Alerts will continue to be submitted when the Director feels appropriate.*

2.10 There may be occasions when Directors feel it is appropriate to provide updates to the DoH/SPPG on an Early Alert which has already been reported, and where there has been a considerable passage of time since the initial report, with possible Ministerial changes. It may be appropriate, therefore, for the Director (or nominee) to communicate with a senior member of staff in the Department of Health (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional officer or Assistant Secretary) regarding the update. This is not mandatory, however it is considered to be good practice. Any telephone update should be advised to the Corporate CSCG Department to allow for a written update to be provided also.

2.11 It is the responsibility of the Trust to comply with any other possible requirements to report or investigate the event being reported in line with any other relevant applicable guidance or protocols [e.g. Police Service for Northern Ireland (PSNI), Health & Safety Executive (HSE(NI)], Professional Regulatory Bodies, the Coroner etc. This should include compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.