8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.

9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.

10. **In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.**

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ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.? Check accuracy of reference

Cases where criminal charges are brought not connected with an investigation by an HSC employer

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12. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

13. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

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CLINICAL PERFORMANCE PANEL

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INTRODUCTION & GENERAL PRINCIPLES

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1. There will be occasions following an extended~~dequate~~ investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.

2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through agreed local processes ~~local informal processes~~ set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).

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3. Matters which may fall under the performance procedures include:

- outdated clinical practice;
- inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- incompetent clinical practice;
- inappropriate delegation of clinical responsibility;
- inadequate supervision of delegated clinical tasks;
- ineffective clinical team working skills.

Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the employer.

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4. Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[18].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to develop ~~raw up~~ an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS

[18] see paragraphs 5 and 6 in section 6I on arrangements for small organisations

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advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

9. The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing;
- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the

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Occupational Health Department as necessary;

- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[19] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

11. Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HSC employer;

[19] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee.

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- a representative of a university if provided for in any protocol agreed between the employer and the university.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HSC/NHS employer, in the same grade as the practitioner in question, should be asked to provide advice. In the case of doctors in training the postgraduate dean's advice should be sought.

12. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

14. The practitioner may be represented in the process by a companion who may be another employee of the HSC body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

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15. The hearing should be conducted as follows:

- the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;
- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the practitioner and/or representative to clarify any

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matters arising from the practitioner's case on which the panel requires further clarification;

- the Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- the panel shall then retire to consider its decision.

Decisions

16. The panel will have the power to make a range of decisions including the following:

<u>Possible decisions made by the clinical performance panel</u>

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:
  - the clinical performance problem(s) identified;
  - the improvement that is required;
  - the timescale for achieving this improvement;
  - a review date;
  - measures of support the employer will provide; and
  - the consequences of the practitioner not meeting these requirements.

In addition, dependent on the extent or severity of the problem, the panel may:

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- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);
- decide on termination of contract.

In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. The panel may wish to comment on the systems and procedures operated by the employer.

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.

18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

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APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

~~***Introduction***~~

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.

21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 24 below).

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22. A dismissed practitioner will, in all cases, be potentially able to take their case to an Industrial Tribunal where the fairness of the Trust's actions will be tested.

The appeal process

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23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

25. The panel should consist of three members. The members of the appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.[20] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;

[20] See Annex A.

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- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[21] who must also have the appropriate training for hearing an appeal.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

26. The panel should call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another HSC/NHS employer [22];
- a senior Human Resources specialist.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS employer in the same grade as the practitioner in question should be asked to provide advice. Where the case involves a doctor in training, the postgraduate dean should be consulted.

27. The Trust should convene the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 29. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:

[21] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.
[22] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

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Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.

34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

35. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.

36. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

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Action following hearing

38. Records must be kept, including a report detailing the performance issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the clinical performance procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Industrial Tribunal.

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Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES update section

Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:

   - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
   - the ability to monitor performance and assure the quality of panellists.

3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list

5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn

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up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.

8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competencies and /or seminars designed to provide background on the specific context of HSC disciplinary procedures.

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REFERRAL TO PROFESSIONAL REGULATOR

5. During the processes described in this framework, reference is made at key stages at which referral to the practitioner's professional regulator should be considered. These include:

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- When a finding of misconduct has been upheld
- When a finding of unsatisfactory clinical performance has been reached.

1. Threshold crieteria for referral under fitness to practice proceedings are referenced in paragraph??? of this framework.

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REFERRAL TO THE NCAS

52. The NCAS is a division of the NHS Patient Safety Agency and was established to assist healthcare managers and practitioners to understand, manage and prevent performance concerns.

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53. 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 HSC Trusts and practitioners. This includes:

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63. immediate telephone advice, available 24 hours;

64. advice, then detailed supported local case management;

65. advice, then detailed NCAS performance assessment;

66. support with implementation of recommendations arising from assessment.

54. Employers or practitioners are at liberty to make use of the services of the 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.

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55. 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 recognise the problem

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as being more to do with organisational systems than a practitioner's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

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

13. clinical performance falling well short of recognised standards and clinical practice which, if repeated, would put patients seriously at risk;

14. alternatively, or additionally, issues which are ongoing or recurrent.

57. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HSC or private sector other than their main place of HSC employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals in its Handbook. [23]. See also circular HSS (TC8) 5/04.

58. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

59. The local action plan should be agreed by both the practitioner and a senior clinician in the organisation. A timescale should be defined for review and completion of the objectives of the action plan and progress documented.

60. Successful completion of the action plan should be documented and this information retained in the practitioner's personnel file

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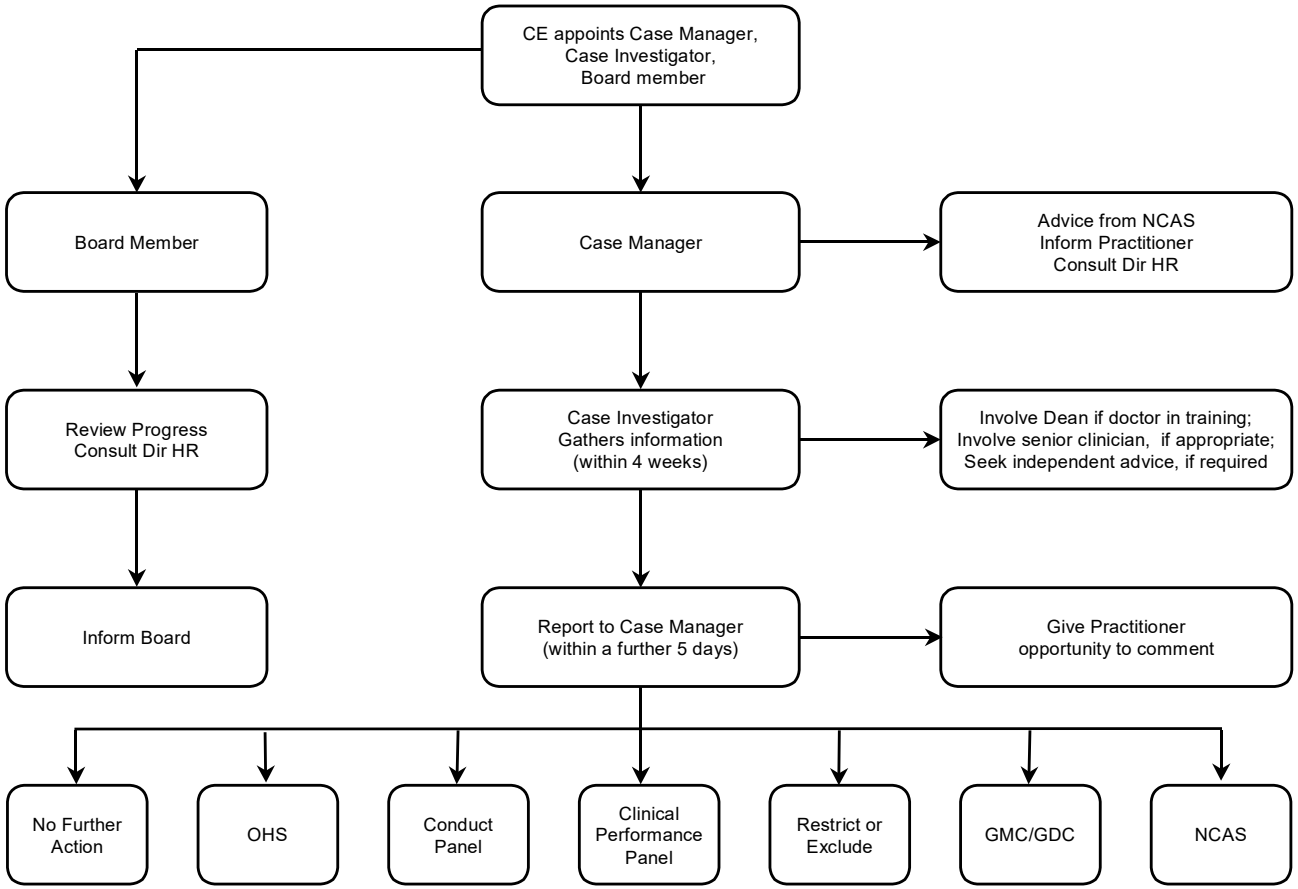

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Appendix 1 – Taxonomy

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MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN NHS

Paul Epstein Q.C.
Cloisters

Maintaining High Professional Standards ("MHPS")

1. As is well-known, in December 2003 the Department of Health issued its framework document, MHPS, for the handling of concerns about doctors and dentists employed in the NHS in England, in two parts, Part I concerned with "action when a concern arises" and Part II concerned with "restriction of practice and exclusion from work".

2. In February 2005 the DoH issued the final framework document, following national agreement between the DoH, the NHS Confederation, the BMA and the British Dental Association.

3. The Secretary of State for Health issued directions coming into force on 17 February 2005 requiring all NHS bodies in England to "implement the framework by 1 June 2005". Those directions provided that HC(90)9 and HSE(82)13 were withdrawn.

Is MHPS automatically part of medical professionals' contracts of employment?

4. Sometimes a doctor or dentist will wish to argue that MHPS remains the procedure that governs his employment, and that MHPS has not superseded it. Sometimes they will wish to argue the opposite.

5. For example, in the first decision in *Mezey v. South West London and St. George's Mental Health NHS Trust* [2007] IRLR 237, HC, Dr. Mezey had been suspended

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from work. It was to her advantage that she be able to rely on MHPS, which more closely limited the circumstances in which he could be suspended when compared with the Trust's specific internal disciplinary procedures.

6. By contrast, in the case of *Nageh v. Southend University Hospital* [2007] EWHC 3375 (QB) the Claimant wished to rely on HC(90)9 for the protection it provided in cases of professional misconduct, and the employer claimed that it did not apply, since it wished to rely on its own internal disciplinary procedures with fewer protections.

7. It is usually a question of fact in each case whether MHPS is incorporated into the employee's contract. Incorporation can be express or implied.

8. As a matter of ordinary contract law, the DoH directions of 17 February 2005 requiring NHS bodies in England to implement MHPS by 1 June 2005 do not have the automatic effect that MHPS is incorporated into the employee's contract of employment.

9. For example, Underhill J. in *Mezey (No.1)* in the HC said at para. 16 that Parts I and II of MHPS issued by the DoH in 2003 "[have] no direct contractual effect as between the Trust and its employees" and in Footnote 5 to his Judgment, in relation both to the 2003 and 2005 MHPS documents stated "The Trusts are not given any power unilaterally to alter existing contractual arrangements".

10. Gray J. in *Gryf-Lowczowski v. Hinchingbrooke Healthcare NHS Trust* [2006] ICR 425 said something similar at para. 56: "It is for the Trust to satisfy me that the contract was thereafter varied so as to incorporate the procedures set out in Part IV of the framework document."

11. There are several cases which decide that the entirety of MHPS is not apt for incorporation, even if MHPS is incorporated into an employee's contract of employment.

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12. An example is *Loizou v Mid-Yorkshire Hospitals NHS Trust* [2010] EWHC 2523 (Admin). That was an application for permission for judicial review. At para. 7 Underhill J. said: "I would observe that the drafting is discursive in character and does not lend itself particularly well to the creation of precise legal obligations".

13. Another is *Lakshmi v. Mid-Cheshire Hospitals NHS Trust* [2008] IRLR 957, QBD, where Simeon Maskrey QC sitting as a Deputy Judge said at para. 26 "I consider that the breadth of [the Trust's internal document implementing MHPS] and the language that it uses is inconsistent with it being regarded as a contractual document in itself".

14. Even in circumstances where the Court has not concluded that MHPS was incorporated into the employee's contract of employment, it has nevertheless in some cases found that there was an implied term (the implied term of trust and confidence) that the Trust follow that procedure.

15. There are several cases that have reached somewhat doubtful conclusions on the issue of incorporation.

16. One is in *Nageh*. That was an interim relief application. The Judge in that case concluded that there was considerable force in the Trust's argument that it would have been ultra vires the Trust to have entered into a contract of employment subsequent to MHPS on anything other than MHPS terms.

17. A further example is *Hameed v. Central Manchester University Hospitals NHS Foundation Trust* [2010] EWHC 2009 (QB). In that case it was common ground that the Claimant was employed on the standard doctors' terms and conditions, including paragraph 189a. That in turn stated that "Issues relating to a practitioner's conduct, capability or professional competence should be resolved through the employing authority's disciplinary or capability procedures which would be consistent with the "maintaining high professional standards in the

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modern NHS" [MHPS framework]…." In this case, the Trust's procedure implemented MHPS. The Court went on to find that "the effect of paragraph 189a of the Terms and Conditions of Service was expressly to incorporate the Trust's Procedure into the Claimant's contract of employment." This conclusion must be open to doubt.

18. When analysing and applying these cases it is important to bear in mind the distinction between those which are decisions on interim relief applications and those which are decisions following final hearings. In an application for interim relief a Claimant usually only has to show that there is a serious issue to be tried as to the contractual terms that he claims apply to him. At a final hearing, the Court will decide which terms in fact or law apply to the employment contract.

19. Additionally, the courts will seek via interim remedies to enforce the MHPS procedures where significant departures from them are threatened by the employer, but it will not seek to micro-manage disciplinary hearings where minor departures are threatened or committed.

20. Smith LJ indicated as much in *Kulkarni v Milton Keynes Hospital NHS Trust* [2009] IRLR 829 para. 22, as did Underhill J. in *Loizou* para. 10: "Where proceedings are vitiated by some fundamental procedural flaw … they should not be allowed to proceed at all."

Unfairness in the Employment Tribunal: Unfair Dismissal Claims

Basic outline of an unfair dismissal claim

21. Where an employee has been dismissed, he has the right, if he has sufficient qualifying period, to bring a claim for unfair dismissal in the Employment Tribunal, under the Employment Rights Act 1996.

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22. Dismissal includes a situation where the employee resigns in response to a repudiatory breach of contract by the employer, and also where a fixed term contract comes to an end.

23. It is for the employer to demonstrate the reason for the dismissal, and that it is a potentially fair reason. Two of the reasons that are potentially fair reasons for dismissal are conduct and capability. A residual category is called "some other substantial reason", usually shortened to SOSR.

24. Whether the dismissal is fair or unfair depends on whether the employer acted reasonably or unreasonably in treating that reason as a sufficient reason for dismissal, having regard amongst other things to equity and the merits of the case, and the size and administrative resources of the employer. This test is different from the test applicable to a claim for wrongful dismissal.

25. It is the case law on these three reasons that is potentially of relevance to conduct and capability dismissals under MHPS.

ACAS Code of Practice and Guide

26. The Advisory Conciliatory Arbitration Services ("ACAS") has issued a Code of Practice on disciplinary and grievance procedures. The current Code was issued in 2009 and is the fifth version of the Code originally produced in 1977. The Code is a statutory code, and may be referred to in the Employment Tribunal.

27. In 2009 ACAS issued a Guide on Discipline and Grievances at Work to supplement the statutory guidance provided by the Code of Practice. It has no statutory force but provides detailed guidance as to the application of the Code of Practice.

28. The ACAS Code of Practice (for reasons that need not be explored in this paper) is brief in the extreme. The Guide offers more detailed guidance

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29. The Guide provides that the employer's rules will often cover matters such as time keeping, absence, health and safety, use of organisational facilities, discrimination, bullying and harassment, personal appearance and the types of conduct that might be considered as gross misconduct.

30. The Guide provides that when drawing up and applying procedures employers should always bear in mind principles of fairness. There should be an opportunity to challenge allegations before decisions are reached, and employees should be provided with a right of appeal.

31. The Guide advises that good disciplinary procedures should be in writing, be non-discriminatory, provide for matters to be dealt with speedily, allow for information to be kept confidential, tell employees what disciplinary action might be taken, say what levels of management have the authority to take the various forms of disciplinary action, require employees to be informed of the complaints against them and supporting evidence before a disciplinary meeting, give employees a chance to have their say before management reaches a decision, provide employees with a right to be accompanied, provide that no employee is dismissed for a first breach of discipline, except in cases of gross misconduct, require management to investigate fully before any disciplinary action is taken, ensure that employees are given an explanation for any sanction and allow employees to appeal against the decision and apply to all employees, irrespective of their length of service, status or say that there are different rules for different groups.

The Burchell test

32. The leading case on the basic procedure to be followed in conduct dismissals is *Burchell v. British Home Stores* [1980] ICR 303: prior to a dismissal, there should be a reasonable investigation, there must be reasonable grounds for the employer to hold the view that the employee is guilty of misconduct justifying his dismissal,

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and the employer must himself subjectively hold that belief. *Burchell* has been followed in capability cases.

33. The requirement for an investigation into misconduct only arises where the misconduct is not admitted. If it is admitted, or if there has been a guilty plea in a criminal court, or the employee has been found guilty, it is only in exceptional circumstances that an Employment Tribunal will find it unreasonable not to take the admission or plea or conviction at face value.

34. As part of a reasonable investigation an employer will make all proper enquiries into the allegations. The purpose of a reasonable investigation is to seek to ascertain the facts underlying the allegations, to identify any facts that may assist the employee and to seek to identify any mitigation that the employee may put forward.

35. Delay in carrying out that investigation may render the dismissal unfair. The ACAS Code of Practice and Guide require action to be taken without unreasonable delay.

The Hearing

36. There is no single rule that can be stated about the content of a fair hearing. It will in each case depend on the facts. Nevertheless, some broad areas of relevance to MHPS can be identified.

37. One issue that frequently arises is as to the composition of the Disciplinary Panel. For some employers it may be difficult to include a panel member who is an employee of sufficient seniority and who has not had some involvement with the matters of complaint. In that case, fairness may require the employer to include amongst the panel one or more individuals from outside.

38. Another is cross-examination of witnesses. It used to be thought, following a case called *Ulsterbus Limited v. Henderson* [1989] IRLR 251, Northern Ireland Court

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of Appeal, that there could never be a requirement for an employer, in order to be found to have dismissed fairly, to permit the employee to cross-examine witnesses.

39. That approach is not now thought to be correct, particularly in light of a later decision, *Santamera v. Express Cargo Forwarding* [2003] IRLR 273, EAT. In that case the Employment Appeal Tribunal said that the test remains one of reasonableness.

40. Usually the person hearing the case is expected by the Employment Tribunal to be the person who makes the decision whether to dismiss. That will not always be the case. However, it is usually thought unfair by an Employment Tribunal for a dismissal decision to be taken by someone other than the hearing officer. The Employment Appeal Tribunal found the dismissal unfair where the decision to dismiss was taken by a person other than the hearing officer in *Budgen & Co v. Thomas* [1976] ICR 344.

41. Another difficulty is where information has been provided by a potential witness in confidence, and that individual is unwilling for his statement to be disclosed to the employee, or to attend for cross-examination. Guidelines on that situation were laid down in *Linfood Cash & Carry Limited v. Thomson* [1989] IRLR 235, EAT. These are appended to this paper.

42. A problem that has sometimes arisen is where the employer does not follow its own procedures. This will not always be unfair. That was decided by the Court of Appeal in *Westminster City Council v. Cabaj* [1996] IRLR 397. The contract provided for a right of appeal to three councillors. The appeal hearing was conducted by only two. The Employment Tribunal found the dismissal fair. The Employment Appeal Tribunal reversed the decision and found the breach so serious that the dismissal was unfair. The Court of Appeal restored the decision of the Employment Tribunal. The Court of Appeal analysed it on the basis that the appeal to two Councils instead of three did not deprive the

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Claimant of the opportunity to show that the original decision to dismiss was unfair.

Appeal

43. It is essential, in order for there to be fairness, that there be a right of appeal against dismissal. Employment cases have held that where there is a procedurally defective disciplinary hearing that results in dismissal, the unfairness can be cured on appeal if the appeal hearing is sufficiently thorough. This will often require an appeal by way of a rehearing as opposed to an appeal by way of review.

Particular parts and paragraphs of MHPS and Employment Tribunal fairness

Part III: Guidance on conduct hearings and disciplinary procedures

General overview

44. Part III of MHPS, concerning conduct issues, contains no detailed guidance as to the procedures to be followed. This is in contrast to the detailed guidance provided in Part IV, which is concerned with capability procedures. The expectation is that the NHS employer will have in place a disciplinary policy or procedure that covers conduct cases, whether that procedure is contractual or not, and that that policy or procedure will be followed.

45. Of course, many of the procedures laid down in detail in Part IV could apply equally to Part III. The Court of Appeal in *Kulkarni* para.48 famously concluded (following an inevitable concession by counsel for the employer and the SOS) that the right of representation in Part IV must also apply to Part III even though the latter is silent about it. There will in future probably be other areas where the courts hold that such parallelism applies.

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Paragraph 4

46. Paragraph 4 provides that each employer will have a Code of Conduct, misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but will generally fall into one of four distinct categories. Paragraph 5 provides that the Code should also set out details of some of the acts that will constitute gross misconduct.

47. In practice there can be considerable variation between employers' disciplinary codes, including as to those acts classified as gross misconduct.

48. If the disciplinary procedure is contractual, with the effect that the employee has agreed to the definitions of gross misconduct contained within it, it will often be difficult, if not impossible, for the employee at an Employment Tribunal to argue successfully that an act that falls within one of those definitions does not amount to gross misconduct.

49. This has the effect that the employer can, if it wishes, classify as gross misconduct acts which other employers would consider to be minor only, and amount only to misconduct.

Paragraph 9

50. Paragraph 9 provides that it is for the employer to decide on the most appropriate way forward and that if the employee considers that his case has been wrongly classified as misconduct he can raise a grievance about it.

51. It might be thought that any situation in which an employee finds himself would fall within either the employer's conduct procedure, or its capability procedure, or its ill-health procedure or any combination of them, but not outside them.

52. A recent decision of the Employment Appeal Tribunal, shows that this is not so. In *Ezsias v. North Glamorgan NHS Trust* EAT/0399/09, 18/3/11, the employee, a

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Consultant Oral and Maxillo-Facial Surgeon, who had the assistance of the BMA during internal hearings, but who represented himself at the Employment Tribunal, was found to have been fairly dismissed by the Trust because of a breakdown of working relationships between himself and his colleagues, in circumstances where the Trust concluded that it was not necessary to apply to him any conduct procedures before his dismissal. That conclusion was upheld by the Employment Appeal Tribunal (N.B. this is a case in Wales. MHPS accordingly does not apply, although the principles expressed by the *Ezsias* decision are applicable to English Employment Tribunal claims.)

53. The essence of the decision is that the Trust fairly dismissed him in consequence of the breakdown of working relationships irrespective of whether Mr Ezsias had been responsible for or had contributed to that breakdown. Plainly, that can be a worrying decision for employees.

54. It can have the consequence that an employee may be dismissed, without the protection of conduct procedures, where there is a breakdown of relationships, even though that employee was not responsible and did not contribute in any way to the breakdown.

55. It was a concern expressed by the Employment Appeal Tribunal at the preliminary hearing stage of the case when allowing the claim to proceed to a substantive appeal hearing. HHJ Serota QC said this: "My colleagues, who have considerable industrial experience take the view that an employer in the position of the [Trust] would have considered itself bound to implement [the Whitley Council procedures], if it intended to assert (as the [Trust] did) that [Mr Ezsias] was at fault for the breakdown in relationships with his colleagues and to dismiss him on that ground, whether or not that ground might be classified as "some other substantial reason"… In the case of a consultant who is given significant protection from dismissal on the grounds of misconduct by virtue of [the] Whitley Council Terms and Conditions, which are negotiated nationally and issued through a Government agency, an employer should not be able to avoid

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implementation of the disciplinary and investigatory procedures by relying on [some other substantial reason] as grounds for dismissal, when the employee's conduct is blamed for the breakdown."

56. No doubt the consequence of the *Ezsias* decision is likely to be an increase in cases where employers seek to avoid the use of conduct procedures, and dismiss for "some other substantial reason".

57. There is therefore likely to be a return to employees making applications for interim relief seeking to compel employers to use conduct procedures.

Paragraph 13

58. Paragraph 13 is concerned with cases where criminal charges are brought not connected with an investigation by an NHS employer. It provides that the employer will have to give serious consideration whether the employee can continue in their job once criminal charges have been made. In other words, it is not concerned with the situation where criminal charges have been admitted or proved.

59. The ACAS Guide provides, under the heading "Criminal Charges or Convictions", that: "An employee should not be dismissed or otherwise disciplined solely because he or she has been charged with or convicted of a criminal offence. The question to be asked in such cases is whether the employee's conduct or conviction merits action because of its employment implications." It also provides that: "In some cases the nature of the alleged offence may not justify disciplinary action – for example, off-duty conduct which has no bearing on employment – but the employee may not be available for work because he or she is in custody or on remand. In these cases employers should decide whether, in the light of the needs of the organisation, the employee's job can be held open."

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60. The ACAS Guide has further provisions, which ought to be consulted in cases of criminal charges unconnected with an investigation by an NHS employer. Care must be taken over paragraph 13 of MHPS, since there is some confusion in the drafting, or at least a lack of clarity, as between charges and conviction.

61. The standard of proof required of an employer in an Employment Tribunal is the balance of probabilities, not the criminal standard of beyond reasonable doubt. However, there are at least two qualifications to that approach.

62. One is that where it is alleged that conduct has taken place which, if true, would amount to serious dishonesty or some other serious offence, the employee is usually entitled to require that the evidence be more cogent than in another case.

63. The other qualification is where the individual (which will often be the case with the medical profession) is working with others, such as vulnerable adults or children, such that even the suspicion or allegation of wrongdoing might be sufficient to justify dismissal. That was the situation in the case of *A v. B* [2010] ICR 849, EAT. The employer was an organisation with responsibilities for children in its work. The claimant was a senior employee. The employee was arrested in Cambodia for suspected child abuse, but was acquitted of any offence. However, the police made a disclosure to the employer that they still had suspicions that he had committed paedophilia. The employer dismissed the employee on the basis of these suspicions. The Employment Tribunal held that that was a fair dismissal, and the fairness was upheld by the Employment Appeal Tribunal.

Paragraph 15

64. This paragraph contains certain "good practice principles set out as guidance" for the employer on agreeing terms for settlement on termination of employment.

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65. Bullet point 4 provides that "Expenditure on termination payments must represent value for money for example, the Trust should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options."

66. However, it need not be thought that an employer is limited to making a payment by way of settlement that would be lower than the amount that the employee could receive by way of award from an Employment Tribunal or the Court.

67. An illustration of this is *Gibb v. Maidstone and Tunbridge Wells NHS Trust* [2010] IRLR 786, CA. This was the well-known case where the Trust dispensed with the services of its long-serving Chief Executive following the outbreak of C Difficile at the Trust, which resulted in a number of deaths.

68. Ms Gibb was entitled under her contract to six months' notice of termination. Her basic salary was approximately £150,000. A reasonable assessment by the Trust of its maximum liabilities to Ms. Gibb arising out of termination of her contract for notice and an unfair dismissal claim would have been approximately £145,000. (This was not the assessment the Trust made).

69. In fact, on advice that the possible band of recovery was greater, the Trust agreed to pay £250,000. It paid part of that sum to her, and then declined to pay the balance. Ms. Gibb sought payment of the balance by a claim in the court. The Trust argued that the agreement was void as being irrationally generous and hence ultra vires.

70. The Judge dismissed Ms. Gibb's claim. The Court of Appeal allowed her appeal. The Court of Appeal was fairly scathing of the Trust's approach. Laws LJ said: "I do not see why an employer such as the Trust, faced in difficult and perhaps controversial circumstances with the need to terminate a long-standing employee's contract, should be obliged in settling terms of severance to disregard

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past service and the employee's future likely difficulties. In such a case a reasonable employer is not limited to the replication of the statutory maximum available to the employee through legal redress. He will not show undue favour; but the constraint of rationality will not close the door on some degree of generosity for the sake of good relations and mutual respect between employer and employee: not only for the sake of the employee in question, but it may be also for the employer's standing and reputation as such. This position is unaffected by the terms of guidance or instructions from the Treasury, neither of which is a source of law." The Judgment of Sedley LJ also repays reading.

Part IV: Procedures for dealing with issues of capability

71. This part of the paper considers some of the paragraphs contained within Part IV of MHPS. However, the comments made are not necessarily limited to procedures for dealing with capability, but will apply also to conduct and ill-health procedures.

Paragraph 11

72. Paragraph 11 provides that employers must ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.

73. Two particular points stand out from the Employment Tribunal experience: where the employee has a disability, the employer will come under a duty to make reasonable adjustments in its procedures for dealing with capability (as well as conduct and ill-health). Additionally, it is sometimes the case that statistical evidence will demonstrate a tendency towards disciplinary charges being disproportionately brought against those of a particular racial group (race claims). These issues are discussed briefly below.

74. As for the duty to make reasonable adjustments, the first question is always whether the employee has a disability. A person has a disability where he has a

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physical or mental impairment, which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities. This is the definition contained within Section 6 Equality Act 2010. The Office for Disability Issues has issued statutory guidance that must be taken into account in deciding whether a person has a disability. It is entitled "Equality Act 2010 Guidance", and can be downloaded from www.odi.gov.uk/equalityact.

75. Many physical and mental impairments will come within the definition of disability. It is not uncommon in employment situations for an individual suffering from depression to have a disability. In contrast to the requirement in a claim for personal injury, it is not necessary for a disability claim in the Employment Tribunal that the mental impairment to be a clinically well-recognised condition. It is sufficient that an impairment exists. Equally, subject to exceptions provided for in the definition of disability and contained within the Guidance, the cause of such impairment is immaterial.

76. Where a person has a disability, and a provision, criterion or practice of the employer puts him at a substantial disadvantage, the employer is under a duty to make reasonable adjustments. That duty is contained within Section 20 Equality Act 2010. The duty is to "take such steps as it is reasonable to have to take to avoid the disadvantage."

77. A provision, criterion or practice will include the arrangements made for holding investigatory, disciplinary and other meetings, as well as the terms on which a person holds his job.

78. On 26 January 2011 the Equality and Human Rights Commission issued a Code of Practice on Employment under the Equality Act 2010. It has not yet been approved by Parliament, but shortly will be. The Code is 326 pages long. It is essential to have regard to the provisions of the Code when considering what adjustments if any might be required of an employer.

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79. The Act does not identify the factors that require to be taken into account in determining whether a step is reasonable for an employer to have to take. However, paragraph 6.28 of the draft EHRC Code provides that some of the factors that might be taken into account include: whether taking any particular step would be effective in preventing a substantial disadvantage, the practicability of the step, the financial and other costs of making the adjustment and the extent of any disruption caused, the extent of the employer's financial or other resources, the availability to the employer financial or other assistance to help make an adjustment (such as advice through Access to Work), and the type and size of the employer.

80. The provisions of the draft EHRC Code relating to disciplinary and grievance procedures are brief (they are the same as the provisions in the current Code, shortly to become the predecessor Code, issued by the Disability Rights Commission.) They are found at page 89.

81. The provisions of the Code may also be relevant in cases concerning return to work arrangements for employees. These may in practice occur more frequently for non-clinicians than for clinicians, but this will not necessarily be the case. In the case of a non-clinician, for example a lecturer, it may be that adjustments have to be made for amplification of his lectures. Adjustments may need to be made to lighting. Adjustments may involve provision of particular seating.

82. The second matter mentioned above is race. In all discrimination claims in the Employment Tribunal, including those on grounds of race, there is a reversal of the burden of proof. This means that where the employee proves facts from which a Tribunal could infer that an act has occurred because of a protected characteristic of the employee (such as race), the Employment Tribunal must conclude that that is the reason, unless the employer provides a non-discriminatory reason that the Employment Tribunal accepts as true.

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83. Importantly, an act occurs because of a protected characteristic where the protected characteristic is any part whatsoever of the reason for the act (other than a de minims reason).

84. It is open to the Employment Tribunal to infer that the act occurred because of a protected characteristic. Such an inference can be drawn through a failure to answer statutory questionnaires. If it is suspected that disciplinary charges have been brought because of a protected characteristic such as race, a statutory questionnaire is a useful tool. It does not need to await the presentation of Employment Tribunal proceedings, but can be served within 3 months of the act complained of (alternatively within 8 weeks of Employment Tribunal proceedings).

Paragraph 12

85. This paragraph provides that those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties.

86. This approach must apply equally in conduct and other types of procedure.

87. It will often be an important question in an Employment Tribunal to identify precisely the nature of the equal opportunities training undertaken by the Panel. Where a question of race discrimination arises, it is common sense that formal equal opportunities training in relation to other protected characteristics, such as disability or religion or belief, may not necessarily be directly relevant. It is often a useful to ask the employer to provide details of the training received by those sitting on the relevant panel, including dates, duration of course, and course contents.

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Paragraph 17

88. Paragraph 17 provides for the procedure that should be followed before the capability hearing. The first bullet provides that the notification of the hearing should be at least 20 working days before it takes place and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel.

89. Employment Tribunal experience demonstrates that there are frequently communications made between a panel and the case manager, either in writing or orally, the contents of which are not conveyed to the employee prior to the hearing. Inevitably many of these communications will amount to no more than procedural communications concerned with arrangements for the hearing itself. However, they can not infrequently include substantive communications concerned with the merits perceived by the manager of the complaints against the employee. In appropriate cases the employee should seek disclosure of the contents of all such communications.

Paragraph 28ff

90. Paragraphs 28 to 46, and Annexe A, concern appeal panels in capability cases.

91. There is no doubt that a fair procedure in a conduct case also requires a right of appeal. The right of appeal may be similar to or the same as the capability procedures within MHPS, although the composition of the appeal panel in a non-capability case may well not include an external member, and not a member of a chairman on a national list.

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Interim Relief

92. There are little-known provisions contained within the Employment Rights Act 1996 that confer power on an Employment Tribunal to order an employer to reinstate or re-engage a dismissed employee, in certain circumstances.

93. The circumstances are that the application for interim relief is presented in the Employment Tribunal within seven days following the effective date of termination of the employment, and that the reason claimed by the employee for his dismissal is one of a specified number of reasons.

94. The full list of reasons for the dismissal for which an application for interim relief can be brought is: health and safety activities, Working Time Regulations, activities as a workforce representative, Trustee of an Occupational Pension Scheme, activities as a TUPE workforce representative, whistle-blowing and workforce recognition.

95. In practice, as regards practitioners in the NHS, an important reason claimed for dismissal is often whistle-blowing. If an employee claims that he has been dismissed for blowing the whistle he may apply for interim relief. This can be a useful weapon against the employer. Naturally, time is of the essence. The case needs to be passed immediately to those advisers dealing with Employment Tribunals.

PAUL EPSTEIN Q.C.
29th March 2011
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LINFOOD CASH & CARRY LTD (appellants) v. THOMSON and another (respondents)
[1989] IRLR 235

GUIDELINES
Where allegations concerning an employee's conduct are made by an informant, a careful balance must be maintained between the desirability to protect informants who are genuinely in fear and providing a fair hearing of issues for employees who are accused of misconduct. Whilst every case must depend upon its own facts and circumstances may vary widely, employers may find the following guidance to be of assistance:

1. The information given by the informant should be reduced into writing in one or more statements. Initially these statements should be taken without regard to the fact that in those cases where anonymity is to be preserved, it may subsequently prove to be necessary to omit or erase certain parts of the statements before submission to others, in order to prevent identification.

2. In taking statements, the following seem important: (a) Date, time and place of each or any observation or incident. (b) The opportunity and ability to observe clearly and with accuracy. (c) The circumstantial evidence, such as knowledge of a system or arrangement or the reason for the presence of the informer and why certain small details are memorable. (d) Whether the informant has suffered at the hands of the accused or has any other reason to fabricate, whether from personal grudge or any other reason or principle.

3. Further investigation can then take place either to confirm or undermine the information given. Corroboration is clearly desirable.

4. Tactful inquiries may well be thought suitable and advisable into the character and background of the informant or any other information which may tend to add or detract from the value of the information.

5. If the informant is prepared to attend a disciplinary hearing no problem will arise but if, as in the present case, the employer is satisfied that the fear is genuine then a decision will need to be made whether or not to continue with the disciplinary process.

6. If it is to continue, it is desirable that at each stage of those procedures the member of management responsible for that hearing should himself interview the informant and satisfy himself that weight is to be given to the information.

7. The written statement of the informant, if necessary with omissions to avoid identification, should be made available to the employee and his representatives.

8. If the employee or his representative raises any particular and relevant issue which should be put to the informant, it may be desirable to adjourn for the chairman to make further inquiries of the informant.

9. Although it is always desirable for notes to be taken during disciplinary procedures, it is particularly important in these cases that full and careful notes should be taken.

10. Whilst not peculiar to cases where informants have been the cause for the initiation of an investigation, it is important that if evidence from an investigating officer is to be taken at a hearing, it should where possible be prepared in a written form.

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

Dr Paddy Woods
Deputy Chief Medical Officer
Joint Chair of Revalidation Delivery Board
Confidence in Care Programme

Department of
Health, Socia
and Public S

Dr Anne Kilgallen
Medical Director
Western Health & Social Care Trust
Trust HQ
Altnagelvin Area Hospital site
Glenshane Road
Londonderry
BT47 6SB

Room C5.17
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Date: 12 September 2011

Dear Anne

DHSSPS – Confidence in Care Programme: Revision of Maintaining High Professional Standards

You will be aware that the Revalidation Delivery Board has been progressing work which originated within the Tackling Concerns workstream of the Confidence in Care Programme. This includes the revision of *Maintaining High Professional Standards(MHPS)*.

The working draft of *MHSP* was considered at the meeting of the Responsible Officer Forum on 7th September. It was agreed that this presented an opportunity to refine the processes and guidance, incorporating lessons learnt from implementation of the current procedures, and from recent events. Initially several key issues have been highlighted requiring further discussion:

- separation of preliminary and extended investigation
- definition of the specific role of the Medical Director
- the role of NCAS
- acceptance by HSC Trusts of rotational Trainees involved in disciplinary processes.

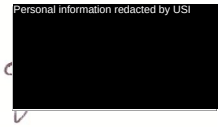
Given the unique involvement of trust medical directors in these processes, you have an invaluable contribution to the proposed revision. Your Trust Medical Director colleagues advised that you are all meeting on Monday 19th September. I would be grateful if you could consider the current draft and comment on the issues set out above and any other you consider relevant.

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

I am also convening a short-life working group comprising an HSC Medical Director, Human Resources Director, Dr McMurray (NIMTDA), and the Chief Dental Officer. The purpose of this group will be to further develop the framework prior to wider consultation. I would be grateful if a Medical Director nomination to the group could be agreed at that meeting and forwarded to Jane Lindsay, (Project Manager, Confidence in Care) at Personal Information redacted by the USI. Jane can be contacted by telephone on Personal Information redacted by the USI.

The date of the first meeting of the Working Group and Terms of Reference will be circulated shortly.

Yours sincerely



Dr Paddy Woods
Deputy Chief Medical Officer DHSSPS

COMMENTS ON DRAFT NEW VERSION OF "MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY.

General Comments:

- Welcome the fact that the previous document is being reviewed and updated.

- Need to ensure that document is "user friendly": ie it needs to flow from one section to another and not jump back and forward between sections. As an example, para 48 sets out the process for setting up an extended investigation but the process for making that decision does not come until para 72.

- There needs to be specific clarification re the roles and responsibilities around Doctors in Training. In particular, in relation to paras 21 and 23-25 there needs to be full transfer of information between NIMDTA and Trusts in relation to any Doctors in Training who are the subject of any procedures under this guidance.

- The terminology in this document needs to be consistent throughout – formal/informal and preliminary (Stage1)/extended (stage 2) investigations seem to be used interchangeably in different sections of this document.

- The document refers very explicitly to NCAS: given the current discussions around the future of NCAS it may be advisable to avoid reference to a particular organisation.

- In the previous document there was a clear distinction between the Informal process and the Formal process in relation to the action taken in response to an investigation. This seems to have been lost from this document. In this regard it would be better to separate out the Investigation stages (stage 1 and stage 2) from the Action stages (informal and formal). For example, para 152 refers to issues being dealt with Informally, but the process for doing this is not mentioned at an earlier stage of the document.

SPECIFIC POINTS.

- Para 28: concerns will be wider than just patient safety:

- Para 36: the distinction between Stage 1 and stage 2 investigation should be more clearly set out. In addition, the document is confusing as to who the investigator should be: para 39 says the investigator should have no connection with the subject whilst para 46 says the investigator should be a senior clinician – in practice this is likely to be someone who has worked with the subject.

- Para 53(a): bringing "all concerns" to the attention of the CEO is not practical and is not consistent with other parts of this document (para 44):

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

- p24: role of Case Manager: "will lead the extended investigation": this sounds like the role of the Case Investigator. Suggest that the Case Manager should "oversee the extended investigation".

- The roles and responsibilities of the Medical Director and the Director of HR need to be set out:

- p26: the wording of the last bullet point (re intractable problems) is not clear and should be reworded.

- Para 56 refers to the Formal process being on p 42 whereas it is on p78.

- Para 71: wording of second last bullet point needs to be reviewed:

- Para 78: further thought needs to be given as to when NCAS (or equivalent) should be involved. I suggest that NCAS be involved at the end of the preliminary investigation if concerns have been found rather than when concerns have first emerged and temporary exclusion has been put in place by the Trust pending the preliminary investigation.

- Para 150: this refers to "local processes" in paras 15-17, but paras 15-17 do not mention "local processes" – this needs to be reviewed.

P Flanagan, Northern HSC Trust 26th Sept 2011

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

Roberts, Naomi

From: Lindsay, Jane
Sent: 15 November 2011 10:43
To: Kilgallen, Anne; Roberts, Margot; Mervyn Barkley; O'Carolan, Donncha; Reid, Simon; kieran.donaghy[redacted]
Cc: Beck, Lorraine; Dardis, Pauline; Davey, Noreen; andrea.armstrong[redacted] Hutchison, Ruth
Subject: Revision of MHPS
Attachments: Revision of MHPS (v4) with changes made 131111.DOC; CiC_Glossary_MHPS.DOC

Importance: High
Sensitivity: Confidential

Colleagues,

Re: Revision of Maintaining High Professional Standards Working Group, Friday 18th November,11:00,C5.17(Dr Woods' Office), Castle Buildings.

I have attached the current revision of MHPS for your consideration ahead of our meeting on Friday. You will note that this is very much a working draft and we look forward to hearing your feedback and suggestions. Also attached is a Glossary that will be developed as the revision progresses.

Our key aims in developing the framework are:

* Incorporate the learning from those who have used the processes and guidance in HSC organisations
* Develop the guidance element of the framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies
* Highlight the need to ensure robust recording when addressing concerns including decision made and how they were reached
* Stress the importance of reviewing investigations at key intervals
* Ensuring that measures required to protect patients and the public are considered at the commencement and throughout an investigation, and reviewed to ensure they still address identified risks.

We have been considering a the range of resources provided by the Labour Relations Agency in work undertaken to date that provide succinct guidance in relation to Conducting Employment Investigations, Handling Discipline and Grievances at Work and Advice on Managing Poor Performance. These documents are available on the LRA website should you wish to review prior to our meeting (link below) http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2.htm.

I have received apologies for this meeting from Donnacha O'Carolon and Kieran Donaghay,both very welcome to provide comments to me by email and I will ensure these are considered at Friday's meeting.

Kind Regards

Jane

Jane Lindsay
Project Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings
Stormont Estate
Belfast BT4 3SQ
[redacted] Mobile [redacted]

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

Meeting of MHPS Working Group
Friday 18th November 2011

In Attendance:

Dr Woods
Dr Kilgallen
Margot Roberts
Mervyn Barkley
Jane Lindsay

Summary of discussion:

1. Current revision of framework is too long and should focus on the formal and informal processes, investigations and roles and responsibilities.

2. There is a degree of ambiguity in relation to roles and responsibilities when commencing an investigation and subsequent action if required. The role of the Medical Director/Case Manager needs clarification; when should they be intimately *involved* in cases and when they should be made *aware*? Their role in relation to decision making is crucial, as is the obligation placed on them to accept and act on the findings of an investigation.

3. Separate section on managing concerns in relation to trainees may be helpful given potential for lack of clarity in relation to role of Employer and that of the Deanery & Responsible Officer. Issues arising where Deanery may have difficulty in securing a placement for a Trainee when there are concerns about his/her performance.

4. There is a need to highlight the importance of organisational policies for performance management of all employees e.g. disciplinary, capability, health and describe their relationship to the Framework.

5. Issues in relation to representation need to be addressed, including the consequences of delay arising from early legal representation.

6. Access to appropriate remediation can prove challenging, and costly, for organisations.

7. Importance of good management skills is crucial when addressing concerns, perhaps a need for training of senior clinicians in this area when Framework finalised.

8. Need to define the use of the word *investigation* throughout the document. May imply formal process when at the beginning of the process we are trying to *establish the facts* in relation to the concern raised.

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

9. Timescales in Framework require revision as often not achievable in practise.

10. The narrative of processes in the Framework should capture any action taken prior to the formal raising of a concern e.g. the role of the critical friend in having a discussion with a colleague about a concern.

Actions Arising

11. **JL** to circulate DH Remediation Report.

12. **AK** to circulate outcomes of exercise undertaken outlining timescales for MHPS processes.

13. **All working group members** to forward suggested changes and areas to be addressed to PW/JL.

14. **AK** to seek further input from MD's.

15. **All working group members** to forward suggested content for trainee section to PW/JL.

16. Following submission of above, Framework will be further revised and a meeting of the Working Group scheduled to consider. Estimated timescale **January 2012**.

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

Roberts, Naomi

From: Woods, Paddy
Sent: 24 November 2011 09:10
To: Colin Fitzpatrick
Cc: Lindsay, Jane
Subject: RE: Review of Maintaining High Professional Standards in NI

Colin

Thanks for this.

We will take account in revising documentation.

Regards

P

From: Colin Fitzpatrick [Personal Information redacted by the USI]
Sent: 23 November 2011 07:49
To: Woods, Paddy
Subject: Review of Maintaining High Professional Standards in NI

Paddy,

Further to our recent discussion regarding your review of MHPS, we have a few comments to make.

First, we agree that MHPS would benefit from revision as experience since it was issued has identified a number of areas for improvement. However, we are concerned that awareness of the document and its provisions is not as widespread within HSC managers as we would have hoped. The experience of our advisors is that we frequently have to remind managers of the provisions and processes within MHPS.

A particular concern is the notification and review of exclusions as described in section II. We find that we are generally consulted before exclusion, although this may be after the trust has already made the decision. We are also concerned that regular reviews may not always occur, in particular the formal referral back to NCAS at the third review. I do not know whether the six month report to the Department occurs. It may be that we should have a discussion about how well this process is working.

Section IV, paragraph 7 would benefit from rewording, in particular the part relating to performance which is fundamentally flawed.

I should point out that we find the wording of Section IV, paragraph 2 to be an improvement on its English equivalent.

The description of NCAS and its services would also benefit from revision.

Finally, we feel that the word informal in the flow diagram on page 43 to be counterproductive. We have found that this encourages an overly relaxed attitude to process and could be replaced by another term such as preliminary.

Colin

Dr Colin Fitzpatrick,
Lead NCAS Advisor (Northern Ireland)

National Clinical Assessment Service (NCAS N I)
Office Suite 3
Lisburn Square House
10 Haslem's Lane

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

Lisburn BT28 1TW

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

Roberts, Naomi

From: Lindsay, Jane
Sent: 27 January 2012 10:01
To: Roberts, Margot; Kilgallen, Anne; mervyn.barkley [redacted] Reid, Simon
Cc: O'Carolan, Donncha; Woods, Paddy
Subject: Maintaining High Professional Standards

Colleagues,

At the last meeting of our MHPS working group we discussed the development of a section within the framework that specifically outlined managing concerns in relation to Trainees (see attached meeting note, point 3).

The link below will take you to an operational framework developed by NES Scotland that may help inform our thinking ahead of the next meeting on 8th February.
[redacted]

Best Wishes

Jane

Revision of MHPS meeting of Wo...

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

Meeting of MHPS Working Group
Friday 18th November 2011

In Attendance:

Dr Woods
Dr Kilgallen
Margot Roberts
Mervyn Barkley
Jane Lindsay

Summary of discussion:

1. Current revision of framework is too long and should focus on the formal and informal processes, investigations and roles and responsibilities.

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

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Actions Arising

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16. Following submission of above, Framework will be further revised and a meeting of the Working Group scheduled to consider. Estimated timescale **January 2012**.

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

Meeting of MHPS Working Group
Wednesday 8th February 2012

Present:

Dr Paddy Woods
Dr Anne Kilgallen
Dr Simon Reid
Margot Roberts
Mervyn Barkley

Summary of Discussion:

1. Current guidance requires simplification in relation to processes, timescales and constitution of performance panels. The role of the Medical Director in the initial stages of an investigation requires clarification as they may be required to sit on a decision making panel at a later stage.

2. The roles of the employer in ensuring practitioners are 'fit for purpose' and the GMC of ensuring 'fitness to practise' was discussed and key distinctions made. This should be clearer in the Framework.

3. There are an increasing number of trainees with identified performance concerns requiring Deanery intervention, as well as correspondence from the GMC to the Deanery outlining required intervention for non-trainee medical staff. It was clarified the Deanery has no obligations to respond in relation to non-trainee staff but Margot felt the MOU with Conference of Postgraduate Medical Deans (COPMeD) may indicate otherwise. Margot undertook to share the MOU with Dr Woods.

4. There was considerable discussion in relation to investigations and the importance of appropriately skilled investigators who have sufficient time to undertake the investigation. It was felt this was crucial to ensure timescales were met and that practitioners who had been excluded where able to return to practice (if appropriate) as soon as possible. The importance of separating investigation from decision making should be clearer in the Framework.

5. Dr Kilgallen provided a flow chart outlining the key MHPS stages that provided a useful visual aid to the discussions. All agreed that the terms 'formal' and 'informal' in the Framework (used to describe processes and types of investigation) were not helpful and should be removed from the revision.

6. The issue of legal representation and the implications this presents for a timely resolution to the concern was discussed.

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

7. Challenges presented to organisations in relation to the rotational nature of trainees were discussed and it was agreed that if one organisation had commenced a conduct/performance process with a trainee, they should not rotate to another Trust until the issue had been resolved. NIMDTA are currently revising their framework for the specific aspects of managing concerns in relation to trainees.

8. Presentational issues with the framework were discussed. The Framework will be further revised and circulated to members for comment. Dr Kilgallen will share the next revision with MD colleagues.

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

Roberts, Naomi

From: Woods, Paddy [redacted]
Sent: 16 April 2012 09:45
To: Lindsay, Jane
Subject: FW: MHPS

Follow Up Flag: Follow up
Flag Status: Flagged

Jane

To note.

P

-----Original Message-----
From: Barkley, Mervyn [redacted]
Sent: 13 April 2012 14:41
To: Woods, Paddy
Subject: MHPS

Dear Paddy

As part of the review of MHPS I thought you would find this interesting. Dr Lynn of NCAS has drawn our attention to Dr Lim v Wolverhampton Hospitals NHS Trust (2011). The Trust's legal advisor, [redacted] has checked and confirmed that the provisions of the English version of MHPS which were crucial to that decision are the same (verbatim) as the equivalent provisions in the NI version of MHPS. In the Lim case, the English High Court granted an injunction to prevent the Trust from convening/proceeding with a performance panel until the matter was referred to NCAS and until NCAS had advised that the dr's performance is so fundamentally flawed that no action plan would have a realistic prospect of success (see section IV para 7 of our version of MHPS). The court held that if the Trust proceeded in the absence of such advice from NCAS, it would be in breach of contract.

This puts employers in a difficult position. You will know we have discussed the difficulties employers can have in arranging assessments. There can be circumstances, particularly in very small teams in which either the relationship between colleagues has broken down or where the safety concerns are such that we could not allow the practitioner to work or there is some technical reason that an assessment cannot be done in the practitioner's workplace that we have tried to arrange placement in other locations. I know from experience this has proved to be impossible in some cases and leaves both the practitioner and the employer in limbo. One way forward would have been to go straight to a performance panel which one way or another would have resolved the position; it would appear this option is closed off.

Perhaps we can discuss at the next meeting of the review group?

Regards

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

Mervyn

In MHPS the onus is on the employer to get the NCAS assessment organised, when this proves impossible the NCAS withdraws and leaves the problem with the practitioner unresolved and the ball in the employer's court.

So from the employer's point of view we seem to have struck impasse. If we cannot get an assessment we cannot take the case to an internal performance panel and in the meantime we could have the practitioner excluded on full pay with no incentive for him to assist in bringing events to a close.

_____

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

Southern Health and Social Care Trust

Medical Directorate

15th January 2013 Our Ref: JS/AB/lw

Ms Jane Lindsay
DHSSPS
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Jane

Revision of MHPS

Please accept apologies for the delay in responding. I have shared the draft paper with colleagues in Medical HR and would like to make the following comments:

- Referring to a Doctor's entitlement to be accompanied by a companion, who may be legally qualified but he/she will not be acting in a legal capacity. In reality our experience is that as soon as an investigation is launched the doctor will contact the MDU (often directed by the BMA). The MDU will almost always engage with solicitors who will immediately start a chain of correspondence directly with the Trust HR Manager on the case. Although the doctor will be accompanied at hearing by the MDU, the representative is simply presenting the case on behalf of the solicitors. Therefore in reality the doctor is legally represented from the outset, with solicitors generating a lot of correspondence directly with the HR Managers throughout the investigation. As Trust's don't generally involve their own legal advisors at an early stage in cases (unless warranted), this correspondence often has to be responded to by (non-legal) HR Manager working with the case investigator on the case.

- The entitlement for the doctor to be accompanied by a Friend – is there any further guidance around the definition of "friend" as this is fairly vague/broad and could cover just about anyone provided they were not being paid for their assistance. If there was any further clarification on this, even confirming they cannot be paid would be helpful.

- Timescales - Our experience of our MHPS investigations is that they are generally much longer than the suggested 4 weeks, given often the complexity and necessity to gather suitable evidence including patient records and seeking witness statements. I wonder if there is anything that can add flexibility here whilst maintaining the importance of completing it as quickly as possible – to avoid Trusts running the risk of possibly being criticised for taking much longer than 4 weeks?

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI /Fax: Personal Information redacted by the USI /Email: Personal Information redacted by the USI

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

- Para 137 – Termination of employment with procedures incomplete - I feel it is important that this section is clear on the Trust responsibilities. We have recently experienced a number of doctors who left during a formal investigation under MHPS, reasons included temporary contract; resignation; rotational junior doctor. In our experience, we completed the investigation but felt that it wasn't appropriate for the Trust to take any further action beyond this i.e. take to a clinical performance hearing or refer formally to NCAS given the doctor was no longer employed. In these cases, we had to consider the case and make a decision on referring the information to the appropriate body (i.e. GMC where doctor had left UK or moved to another Trust in UK and NIMDTA for doctor in training). Our legal advisors agreed that it would be very difficult for the Trust to take any different action in these cases. Undoubtedly Trusts should deal with all the concerns and complete the investigation wherever possible but I think it should be clear about the expectations of taking it further and reaching a final decision?/conclusion after they have left employment.

- Disciplinary and Clinical Performance Hearings - Some of the case law around doctors and MHPS makes reference to independence of panels and I am wondering if there should be further guidance around this to protect Trusts?

- Disciplinary and Clinical Performance Hearings – Again some of the case law talks about legal representation in limited circumstances for doctors/dentists as the outcome of the case is argued to substantially influence an employee's right to work in their chosen career – will the revised MHPS provide any guidance on the application of case law on this issue.? http://www.medical-journals.com/index.php?option=com_content&view=article&id=219&Itemid=111.

- The document written by Paul Epstein from Cloisters is useful to consider in terms of the failings they see in the current MHPS document. http://www.cloisters.com/news-pdf-downloads/maintaining-high-professional-standards-in-modern-nhs-2.pdf. He refers to for example the lack of definition to be followed in pure conduct cases (which can vary between employers particularly for gross misconduct) and how case law has therefore drawn comparisons with Part IV (clinical performance hearings).

Yours sincerely

Dr John Simpson
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI /Fax: Personal Information redacted by the USI /Email: Personal Information redacted by the USI

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

LRA COMMENTS ON DHSSPSFRAMEWORK FOR MANAGING CONCERNS ABOUT DOCTORS AND DENTISTS IN THE HSC

Page	Section number	Comments
Cover		The document is entitled a "framework for managing concerns..." and as such is much broader than any common or garden grievance procedure. The document must cross reference other professional codes of conduct and performance management systems as well as policies such as whistle-blowing in order to identify which takes precedence and whether or not they are "apt for incorporation". (MMA)
4	4	The merging of performance and conduct is concerning and whilst there may be overlap they are distinct categories and should be treated as such to prevent falling into a "mislabelling" trap and thus question the employers' reasonableness . (MMA)
5	10	The status of the document seems to be that of an overarching framework document within which local documents need to align with thus begging the question of what standing this document has on an individual level. (MMA)
5	11	Paragraph 11 perhaps warrants greater scrutiny and coverage as the tone and brevity infer a lack of corporate responsibility and smacks of abdication of liability. (MMA)
7	16	Paragraph 16 needs more than a cursory reference to professional regulatory processes as the two are often inextricably linked (employer and regulatory body expectations) and there is inevitable cross-over and although paragraph 20 goes some way towards this it lacks sufficient detail in terms of cross-over relationship, relationship with CPD/fitness to practice/ re-validation/standard of care, outcomes and so on. (MMA)
12	35	Paragraph 35 should detail vehicles for voicing concerns – grievance, whistle-blowing, complaint forms etc whilst addressing breach of duty of care by omission rather than simply act. (MMA)
12	36	Paragraph 36 should also cross reference data protection and perhaps freedom of information) and the notional concept of a duty of candour. (MMA)
13	40	Paragraph 40 may now need to be aligned with the pending amendments to the Data Protection (NI) Order 1998. (MMA)

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Page	Section number	Comments
14	41	Paragraph 41– does exclusion mean or include temporary paid suspension? And are the alternatives to this listed on paragraph 44 (page 19)? (MMA)
19	45	Need to be more specific about the nature of information sharing gateways as this is often contentious. (MMA)
21	48	The combination of desktop work and preliminary interviews can be tricky in terms of where the demarcation lines are in terms of depth of probe etc. Further the process of informing senior ranks about the investigation must ensure that there is no room for process contamination or accusations of fait accompli. (MMA) We would recommend that clear terms of reference are identified during the preliminary investigation (RM)
22	51 50/51	Is there a pro-forma for investigative reports – to help ensure consistency? (RM) Paragraph 50 and 51 – what are the practical out-workings of " frequent and factual recording" and the practitioner being given a chance to "comment on the investigation report"? This in turn puts a question mark over the investigators decision making responsibilities – ie can he/she decide there is no case to answer and as such provide the employee with the basis of an appeal route for what could effectively be a de facto decision on a grievance? (MMA)
24	53	Preliminary investigations rarely verify/refute the substantive issues in their entirety. (MMA)
24	54	The last sentence infers recorded "soft intelligence" for future use and may well be challenged. (MMA)
25	55	Is there not an issue that there may well need to be an extended investigation immediately after the pre-lim? (MMA)
26	62	Might be worth adding a comment that such exclusion is with pay. (RM) An extended exclusion will have the net effect of further eroding if not completing the breakdown in relationships within a team and this must also be given due regard. (MMA)
26	66	The practicalities of suggesting alternatives to exclusion whilst in exclusion may make such a system inept. (MMA)

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Page	Section number	Comments
27	69	Should detail the possible ramifications of notifying the appropriate regulatory body. (MMA)
29	70	Should detail relevant bodies associated with child protection, data protection and so on. (MMA) When you say in the second bullet point that the investigation has not resulted in a conclusive decision, could you explain what you mean – e.g. is this because there is insufficient evidence, or cause for concern has been identified, etc. (RM)
29	72	Grade consciousness can be problematic regarding investigations. Is this the case here and, if so, how is it addressed? (MMA)
30	74	I note that no right of accompaniment is given at Preliminary Investigation – is there a reason for this. There is of course no legal requirement to provide the right to be accompanied. (RM) Also, for completeness you may wish to ensure that it is clear that the employer is complying with the statutory right of accompaniment by mentioning Trade Union Representative – while this is likely to be viewed as a representative body like BDA or BMA it is worth ensuring legal compliance. (RM) The case of Kulkarni v Milton Keynes Hospital NHS Foundation Trust and anor (2009) stated that where an employee had a limited right to be represented in a disciplinary hearing by a legally qualified representative (such as this framework states) a further contractual provision stating that such a representative would not be permitted to represent the employee 'in a legal capacity' was devoid of meaning and should be disregarded. Once a legal representative is admitted they are entitled to use all their professional skills in the employee's service. (RM) The concept of legally qualified companions (especially where there is a restriction on the capacity in which they are present) has been the subject of extensive case law from 2010-2013 (especially "Kulkarni" and "Puri" and "Mattu") and now surely this area is ripe for re-examination ! (MMA)
31	76	The requirement for equal opportunities training as a de facto pre-requisite seems odd. Surely training in employment investigations would be a higher priority. (MMA)

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Page	Section number	Comments
31	79	Does not address a key issue which is the source of the allegations which is more often than not a contentious matter. The paragraph must ensure that in giving "their view of events" that this is clearly demarked as part of the investigatory process rather than pleading a defence in a disciplinary hearing context. (MMA)
32	82	What is meant by "...inform the Terms of Reference"? Does this mean to ensure alignment or to amend or extend (as this is often the net effect) (MMA)
32	83	Warrants greater attention to detail regarding the objectivity of the investigator. (MMA)
33	85	Warrants greater detail and requires a cross reference to Data Protection and Freedom of Information protocols (MMA)
33	86	The inclusion of the phrase "...within the boundaries of the law..." seems a little bizarre and the remainder lacks detail. (MMA)
33	89	If a CI is doing the pre-lim (as suggested in highlight) then they potentially do actually make a decision. (MMA)
34	90	Why does the practitioner not simply contest factual content when they are giving their view as part of the investigatory interview process? (MMA)
34	92	Why is there no provision for interviewing at home or at neutral venue or for phone calls or e-mails as substitute processes? (MMA)
34	94	"...or have a representative attend in his absence" – this is likely to be challenged and once again raises issues aligned to Article 6 of the Human Rights Act. (MMA)
35	95	Should such measures be 'temporary' or are you referring to more permanent arrangements? (RM)
36	97	And mentioned earlier also – I wonder about the necessity of keeping investigative records (where there has been no case to answer/further action required) on the employee's personnel file. I would be concerned that this could prejudice further investigations – either way. Perhaps such records should be kept but in a separate investigations file. You could check this with the Information Commissioner. (RM) Queries and challenges are likely around soft intelligence, contrary case law decisions etc. (MMA)

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Page	Section number	Comments
37	104	As before – you may wish to make clear that such exclusion is temporary. (RM) Infers that exclusion can effectively be used in a semi-disciplinary sanction way as opposed to a paid suspension way. (MMA)
40	119	It is not entirely clear what is meant by the expression "irretractable problems" – worthy of explanation and example. (MMA)
43	122	Needs to detail potential conflicts of interest and detail provisions regarding corporate and individual conflicts of interests registers and duties to declare and recuse accordingly. (MMA)
44	125	Needs to be put into an NI context regarding the ISA. (MMA)
44	126	(Second bullet point) Should address the issue of "gagging clauses" per se and the overall concept of confidentiality agreements and where they sit in a variety of contexts involving termination by mutual agreement as per the Francis Report 2013. (MMA)
44	127	Lacks detail in the tension regarding confidentiality and Freedom of Information, the public interest and the law on libel (due regard to NI differences in the law here) (MMA)
45	128	Is much too cursory given the importance and the additional unmentioned aspects of the key data protection principles. (MMA)
46	General 3	As noted by another commentator, I think it is necessary to provide some detailed guidance on what could be viewed as Personal and what could be viewed as Professional Misconduct. Part 2 para 1 (page 46) – What is covered under "personal misconduct" – seems widely ambiguous and likely to be challenged. Where is the independent professional advice obtained and what reliance is placed on it therein? (MMA) Replace conduct with 'disciplinary' as noted by another commentator. (RM)
47	6	Is there a generic employer "Code of Conduct" and if so, what is its "incorporated" status? (MMA)

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Page	Section number	Comments
48	7	"....failure to give proper support...." is likely to be challenged given the nebulous nature of such a construct. (MMA)
48	8	I think this could unnecessarily prolong procedures if an employee is entitled to raise a grievance if they feel that there has been a misclassification of misconduct. I would have thought that the purpose of the conduct/clinical performance procedures is for such a finding to be made. (RM) Seems a bizarre process and in no way conducive to good employment relations – Need to re-examine. (MMA)
49	13	Could you perhaps give some examples of what action might be taken in the event that the practitioner is acquitted following legal proceedings. (RM) This raises the spectre of soft intelligence again and is likely to be challenged. There may be mixed messages drawn from the paragraph regarding risk to patient safety and reputational risk to the organisation. (MMA)
49	14	The application of the test of proof downgrading from "beyond reasonable doubt" to "Genuine, reasonable and honest belief" may bring challenges regarding double jeopardy. (MMA)
51	3	The issue of having two "labels" is frowned upon by industrial tribunals as there must normally be a singular reason for dismissal. Confusion at this stage may compound procedural protocols and thus need to be clearly demarked. (MMA)
52	9	"...copies of all evidence..." Are these in un-redacted form? What are the exact protocols on – late evidence submission, anonymised witness statements, proceedings in absentia, unwilling witnesses and failure to obey lawful instruction to co-operate with an internal process, the fairness of "downgrading" witness evidence in a statement due to unavailability through no fault of their own, the reason for having witness accompaniment? (MMA)
54	12	What are the agreed / substantively accepted reasons for objecting to a panel member? (MMA)
55	13-16	Paragraphs 13,14,15, 16 – Need to be reviewed and re-written in their entirety (see comments on paragraph 74 above regarding case law developments, existing case law on quasi-judicial approaches –(such as cross examination) to internal hearings). The spirit of Paragraph 13 is totally at odds with the practice set out in Paragraph 16. (MMA)

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Page	Section number	Comments
57	18	Warning duration can be very contentious and is an area frequently challenged. (MMA)
57	19	What are the protocols guiding "consideration must be given to referral to GMC.." and how does this cross over work in practice? The nexus between being dismissed by the employer and being unable to practice a profession by virtue of being struck off by a regulatory body is a key issue in recent case law. (MMA)
57	20	What is the enforceability status of a recommendation? (MMA)
58	23	What is meant by "clarification" of the practitioners right of appeal. There may be a negative inference drawn that the grounds of appeal are perhaps limited only to procedural defects or the arising of new facts/ evidence. (MMA)
59	24	When you say develop an internal appeal process do you mean follow normal appeal processes – this is a bit confusing and sounds like you mean something differently entirely. A fundamental requirement of disciplinary processes is that there is a right of appeal and it should be inherent in all procedures. Would suggest that you re-word this section. (RM)
59	25	The term used "....for their case to be reviewed" infers that appeals are always of a review nature as opposed to a re-hearing (De Novo), is this intentional? How does an "assessment" vary from an investigation?, the expression "evidence heard" infers that non-oral evidence is somehow ignored. When does it become apparent that the De novo /re-hearing approach to appeals becomes necessary in the context of new evidence only coming to light post-investigation but not due to a procedural flaw? (MMA)
60	29	The conflict of interest/recusal provisions here relate only to "previous direct involvement", what about other requirement to recuse situations? The tone of bullet point 1 is at odds with paragraph 13 on page 55. (MMA)
61	31	As noted by the other commentator, while I believe that you should taken any concerns or objections into account regarding panel members and determine if there is any cause for concern, I do not believe that this requires the employer to always check with the employee that they are happy about the panel members. I would suggest that you re-word this section to say something like, if employees have any concerns/objections with panel members they should raise it with..... (RM)
62	35	Witness statements from witnesses called via the initiative of the panel can often prove contentious in terms of protocols. (MMA)

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Page	Section number	Comments
62	36	Partial re-hearing can be contentious in that it is normally review or re-hearing as opposed to some sort of half-way-house. (MMA)
63	37	Does not give an indication on things such as – advance timescales, redacting contents, discovery protocols and so on. (MMA)
63	38	See previous comments on representation and the current thinking derived from human rights case decisions. (MMA)
63	39	What in practice is meant by "...question the management case and any written evidence"? (Cross-examine with a view to undermining?) (MMA)
63	40	See previous comments regarding cases such as "Ulsterbus" and "Santamera" and the aforementioned tone of paragraph 13 on page 55. The mitigation component appears to be some sort of plead of clemency, Is this the case? (MMA)
63	42	What is the exact nature of the clarification protocol whereupon the panel is required to elucidate upon its decision? (does it, for example, include – underpinning reasoning or something more akin to Industrial Tribunal rules on decisions) (MMA)
64	43	See previous comments on information gateway sharing and how it is put into operation and who the onus is on to share. (MMA)
65	44	See previous comments re "...trained in legal aspects.." (MMA)
67	General	I think it would be worth reiterating at the outset of this section that there are alternatives to exclusion and detail what these are. (RM)
67	1	Why at this juncture is Article 6 cited when it has cause to be cited at several other points throughout the document? (MMA)
67	2	Is exclusion the same as paid precautionary suspension? (MMA)
69	7	Final bullet point – What is the status of the "...representation..."? (MMA)
69	9	Is there any direction on the term "..reasonable and proper cause to exclude."? (MMA)

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Page	Section number	Comments
70	12	Should the detailed alternatives to exclusion not be given greater prominence and consideration. The coverage seems cursory and could be deemed tokenistic. (MMA)
71	18	What about a practitioner who enters the premises in his or her capacity as a patient or accompanying a family member who is a patient? (MMA)
72	19	The fact that the exclusion is paid should be highlighted at an earlier juncture. What about previously agreed secondary employment which was in place prior to exclusion with employer permission?. Need to clarify protocols such as taking leave during exclusion to relieve stress etc (MMA)
73	21	What about secondary employment unrelated to the "health industry?". (MMA)
73	23	What are the new provisions regarding gardening leave per se? (MMA)
78	2	I think that it is probably worth saying at the end of the first bullet point that the overriding objective is also to ensure a fair and transparent process, to ensure that the practitioner's well-being is considered also. (RM)
79	5	Paragraph 5 - is a direct lift from LRA material and the remaining paragraphs of the appendix are derived from LRA material but with minor variations which are not highlighted as being DHSSPS material added to LRA material and could lead to confusion over what exactly the LRA say about investigation good practice! (MMA) I would suggest that you either copy the guidance material exactly as it is or provide a link to the guide for users to follow. (RM)
81	7	Seems to contradict earlier provisions regarding and precluding the involvement of non-employees in the process. (MMA)
81	8	Seems confused in parts and raises questions about interpretation of witness statements, older evidence being less credible?, what can be adduced from written statements?, the nature of soft intelligence, the weight attributed to anecdotal evidence and indeed the legal "rules of evidence". (MMA)

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

Roberts, Naomi

From: Muldoon, Angela [redacted]
Sent: 03 January 2018 11:50
To: Dawson, Andrew
Cc: McAlister, Damian; 'Weir, Myra [redacted]'; 'McConnell, Ann [redacted] 'Brownlees, Elizabeth'; [redacted] Kennedy, Jacqui; Dowie, Heather; 'Spence, Tracey'; 'Jo McGuinness'; 'Roy, Frances'; 'Mallagh-Cassells, Heather'; Spence, Doreen; Woods, Paddy
Subject: Maintaining High Professional Standards in the Modern HPSS
Attachments: A DAWSON - 18-02.pdf

Andrew

Please find attached correspondence from Mr Damian McAlister in relation to Maintaining High Professional Standards in the Modern HPSS.

Kind Regards

Angela Muldoon
on behalf of Damian McAlister

Angela Muldoon
Personal Assistant to Martin Dillon, Chief Executive
Personal Assistant to Damian McAlister, Director of Human Resources and Organisational Development

Belfast Health and Social Care Trust
caring supporting improving together

Trust Headquarters
A Floor, Belfast City Hospital
Lisburn Road, Belfast, BT9 7AB

Tel: [redacted]

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

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr. Martin Dillon

Chairman
Mr. Peter McNaney, CBE

Ref: DMAO 18/02

3 January 2018

Mr. Andrew Dawson
Interim Director of Workforce Policy
Castle Buildings
Stormont Estate
BELFAST BT4 3SQ

Dear Andrew

Maintaining High Professional Standards in the Modern HPSS

You will be aware that the above guidance was developed in 2005 to assist in the management of issues of personal and professional conduct pertaining to all medical and dental staff within the Health and Social Care system. I believe the guidance document that was issued within NI largely mirrors that which was developed for use within the NHS elsewhere in the UK.

I am writing to ask that consideration be now given to a review of the documentation and its content. I believe that while the clear intent of the guidance is being, and has been, fulfilled by its operation over time, in reality its practical application in parts has become increasingly more difficult to the result that cases are now taking an inordinate and unacceptable amount of time to progress.

I would welcome a discussion about this at a forthcoming HRD Forum and I have copied to Dr Paddy Woods and my Trust HR Colleagues for information.

Yours sincerely

Personal information redacted by USI

Damian McAlister
Director of Human Resources and Organisational Development

Copy List: Dr P Woods – Deputy CMO, DoH
Trust HR Directors
Mrs J Kennedy – HR Co-Director, BHSCT

respect & dignity openness & trust leading edge learning & development accountability

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

HR Directors Forum

8 October 2018

NHSCT HQ BRETTEN HALL

Attendees

DoH:
Andrew Dawson (Chair)
Paula McGeown
Frank McGuckin
John Grills
Liz Hynes

HSC:
Ann McConnell WHSCT
Vivienne Toal SHSCT
Roisin O'Hara NIAS
Maryna Chambers NHSCT
Myra Weir SEHSCT
Karen Hargan BSO

1.	**Welcome and Apologies**
	Andrew welcomed everyone to the meeting. He advised that Paula McGeown had now replaced Marc Bailie. Apologies were received from Elizabeth Brownlees, Jacqui Kennedy and Ivan Ritchie.
2.	**Minutes from Previous meeting**
	The minutes from the previous meeting were agreed.
3.	**Action Log**

Irrelevant information redacted by the USI

[redacted]

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

Irrelevant information redacted by the USI

[redacted]

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

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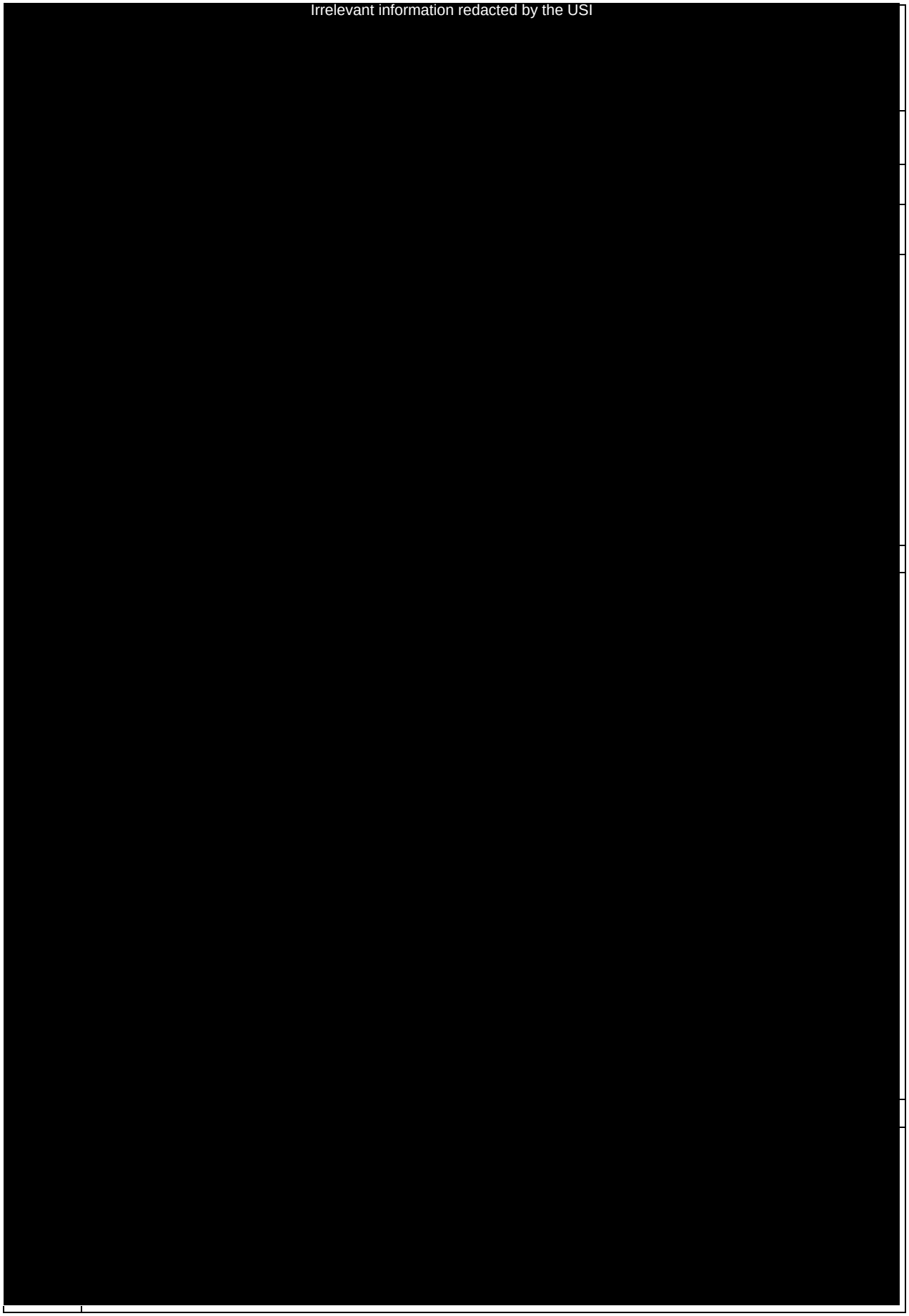

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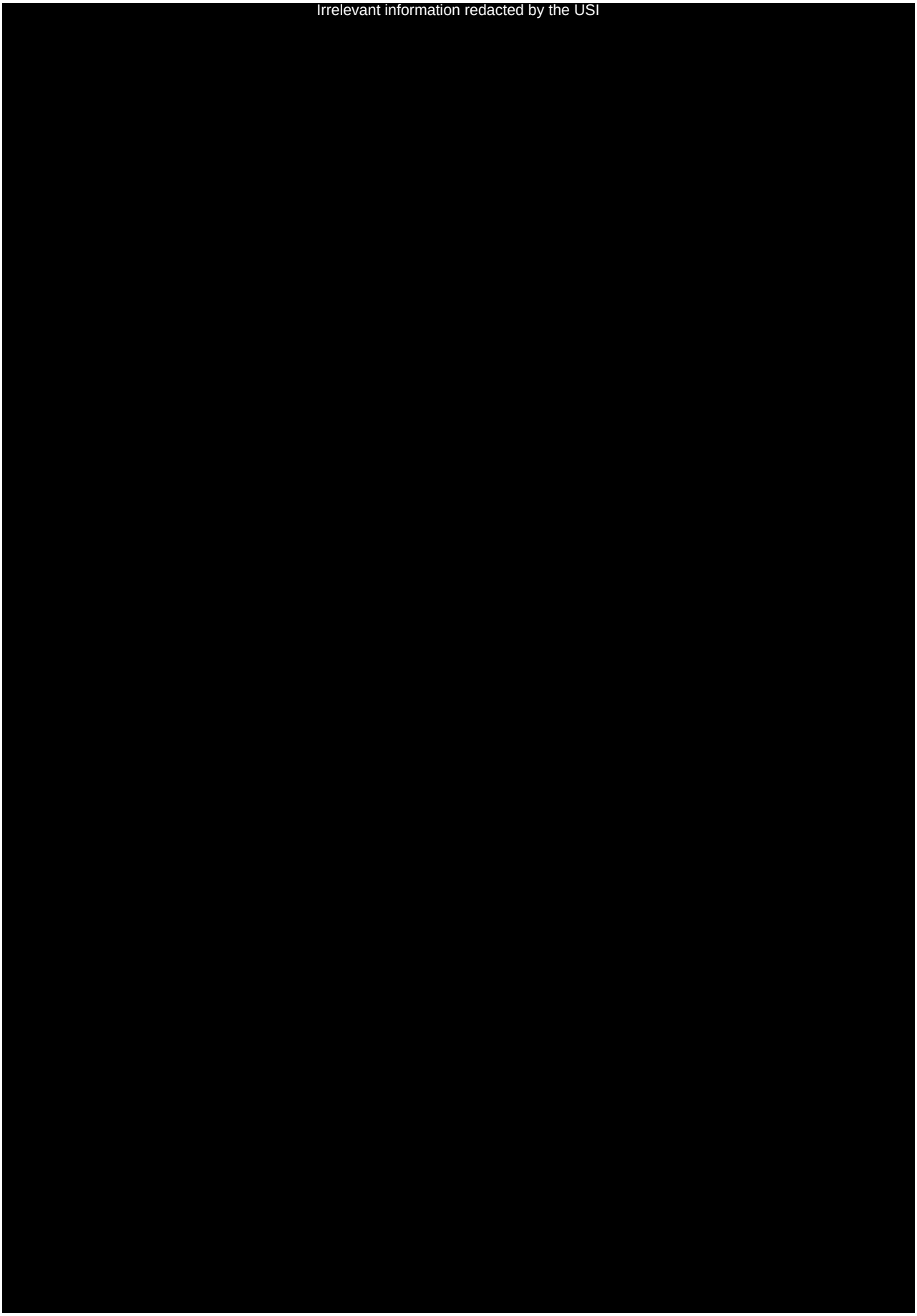

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Irrelevant information redacted by the USI

[redacted]

18.7 – Maintaining High Professional Standards

Vivienne raised this issue and Liz advised the HR Directors that this piece of work was yet to start, but that it is anticipated that the review of this policy would begin in the new year.

Liz also advised that a review of the Recruitment and Retention Premia policy was due to begin in the new year, and that a Task and Finish Group would be required for both work streams.

Action 86/18 – Liz to update the HR Directors on the Review of Maintaining High Professional Standards.

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

HR Directors Forum

14 October 2019

E5 25, Castle Buildings

Attendees

DoH:
Andrew Dawson (Chair)
Chris Wilkinson
Alison Dunwoody
Liz Hynes
John Grills

HSC:
Alison Andrews BSO
Siobhan Hynds SHSCT
Myra Weir SEHSCT
Oonagh Burns NHSCT
Ann McConnell WHSCT
Ivan Ritchie BTS
Maxine Paterson BSO

1.	**Welcome and apologies**
	Andrew welcomed everyone to the meeting. Apologies were received from Vivienne Toal, Paula Smyth, Karen Hargan, Roisin O'Hara and Jacqui Kennedy.
2.	**Minutes of previous meeting**
	The minutes of the previous meeting in September were agreed.
3.	**Action Log**

Irrelevant information redacted by the USI

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

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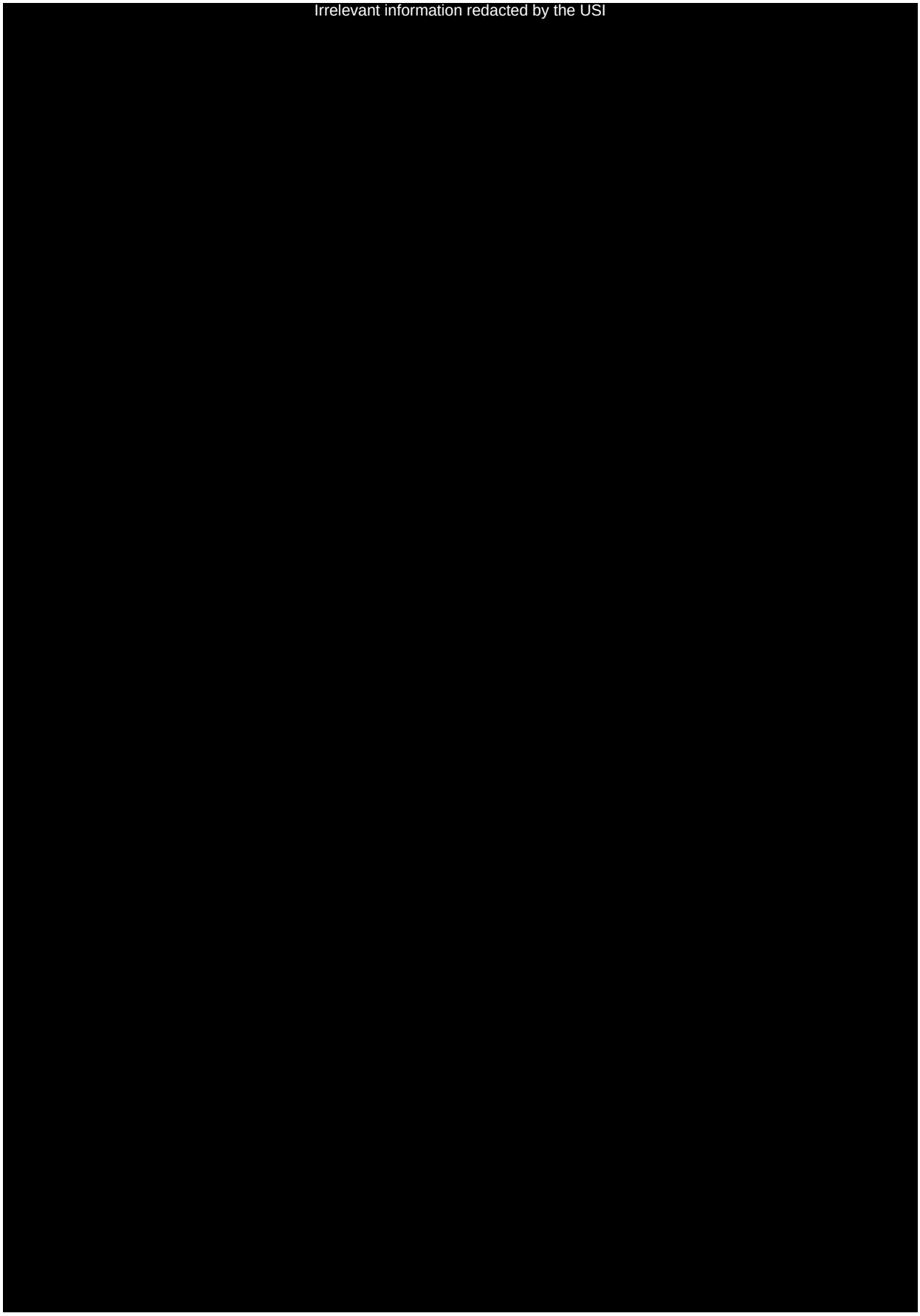

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[redacted]

	Maintaining High Professional Standards Liz advised that flowcharts have been amended and agreed.

[redacted]

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

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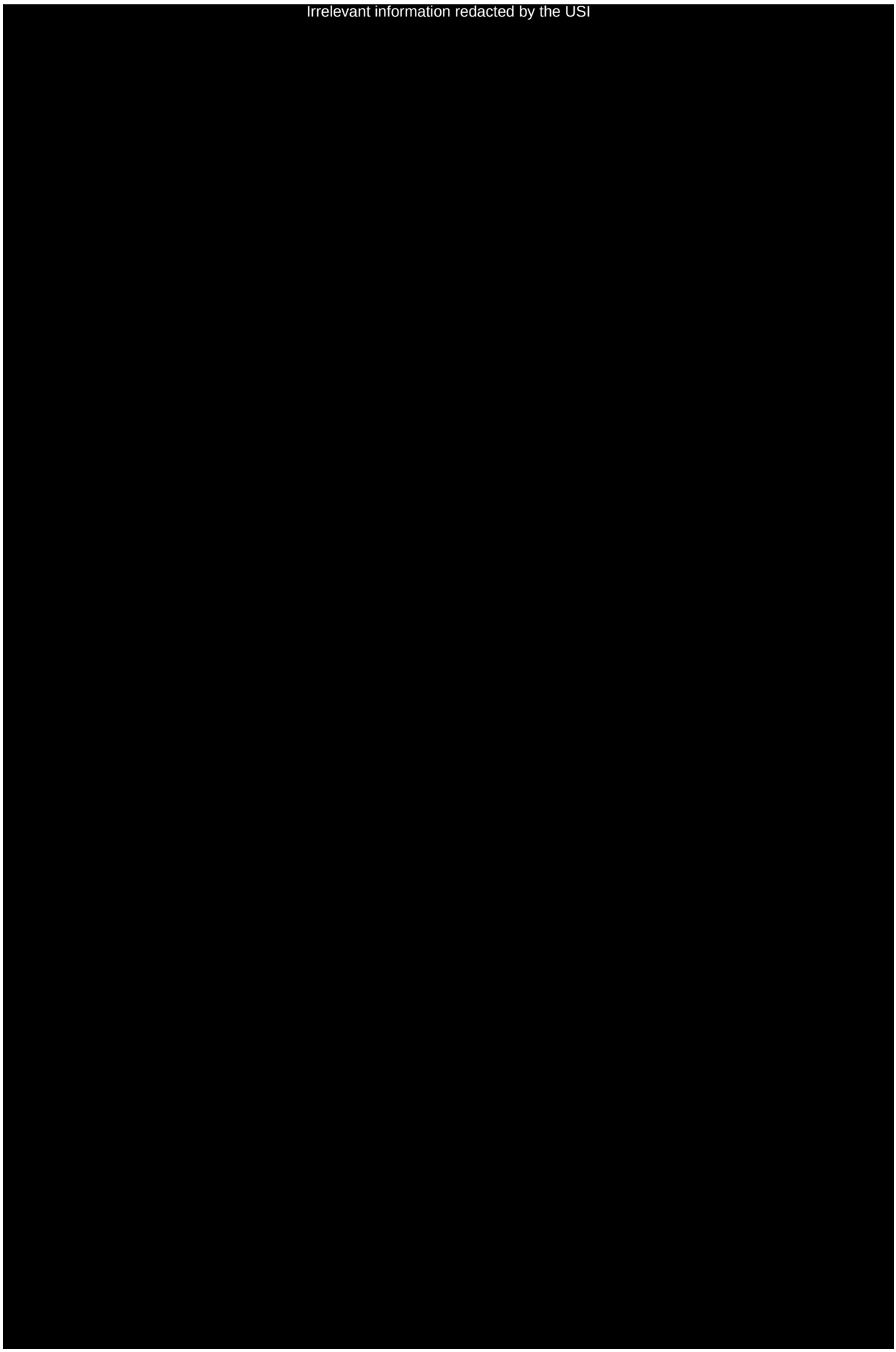

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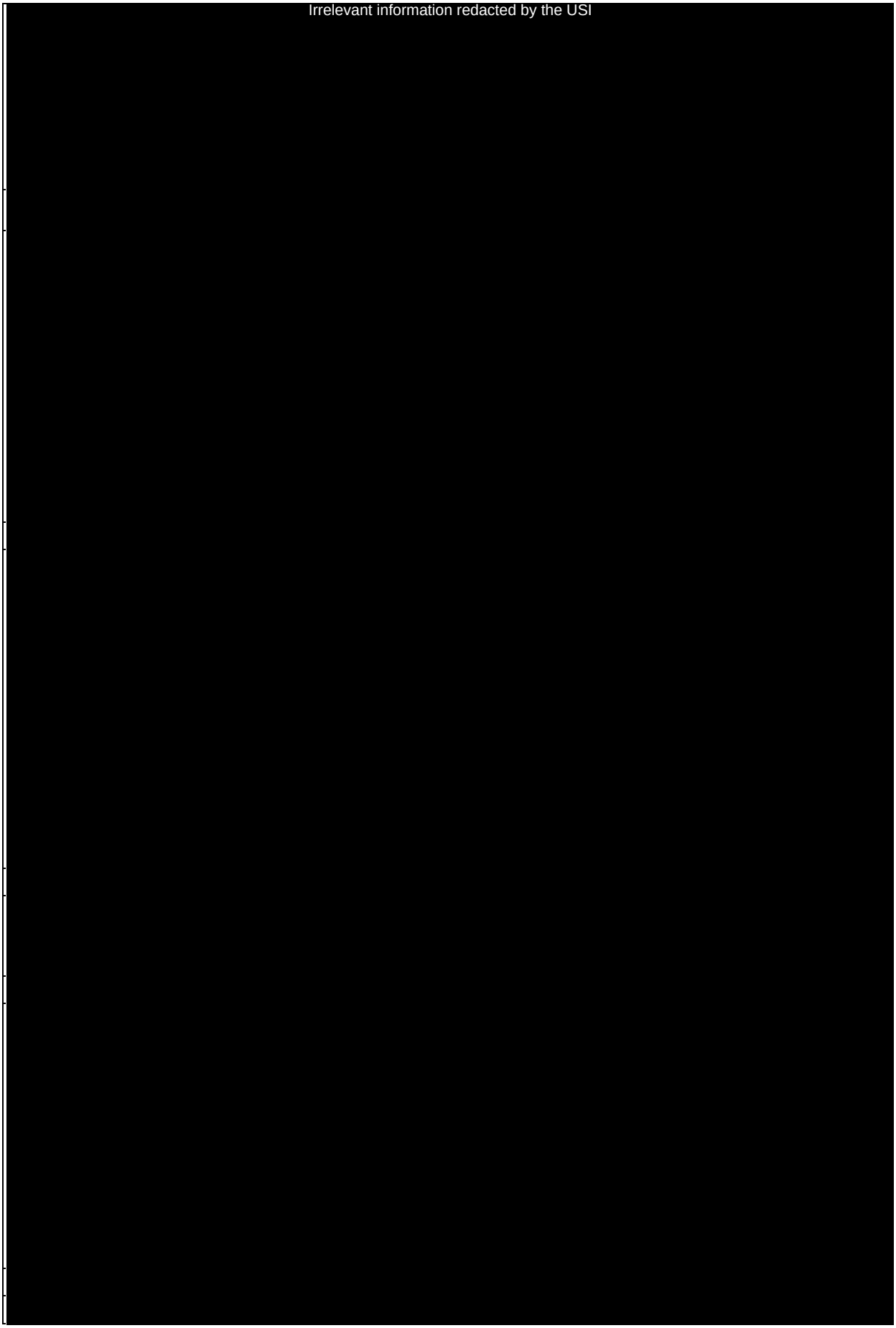


Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

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

HR Directors Forum

13 January 2020

Video Conference Room, Castle Buildings

Attendees

DoH:
Andrew Dawson (Chair)
Chris Wilkinson
Paula McGeown
Stephen Galway
Liz Hynes
John Grills

HSC:
Jacqui Kennedy BHSCT
Paula Smyth BSO
Vivienne Toal SHSCT
Myra Weir SEHSCT
Karen Hargan NHSCT
Ann McConnell WHSCT
Ivan Ritchie BTS
Michelle Lemon NIAS
Owen Harkin NHSCT

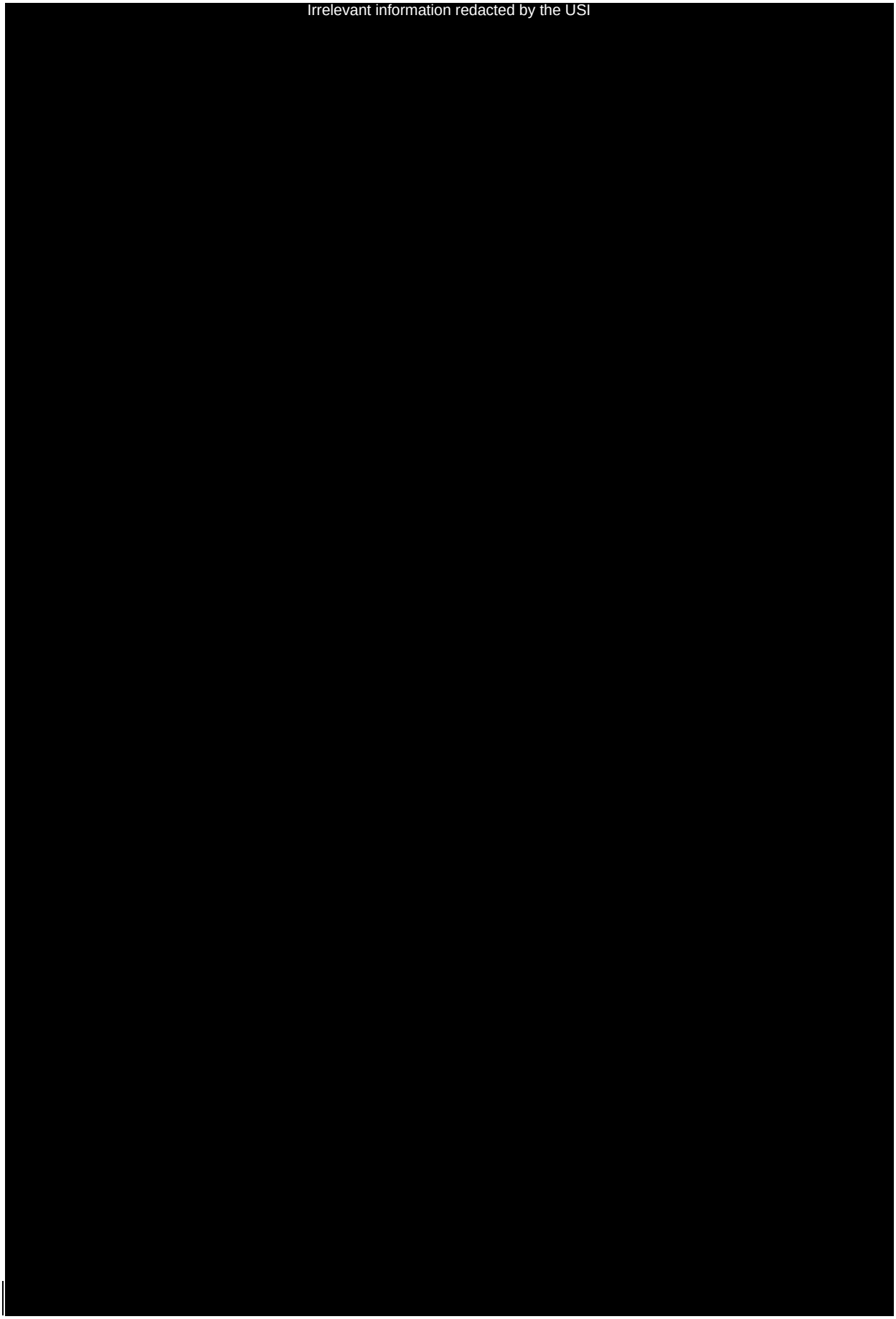
1.	**Welcome and apologies**
	Andrew welcomed everyone to the meeting.
2.	**Minutes from Previous Meeting**
	The minutes from the previous meeting in November were agreed.
3.	**Action Log**

Irrelevant information redacted by the USI

[redacted]

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

Irrelevant information redacted by the USI



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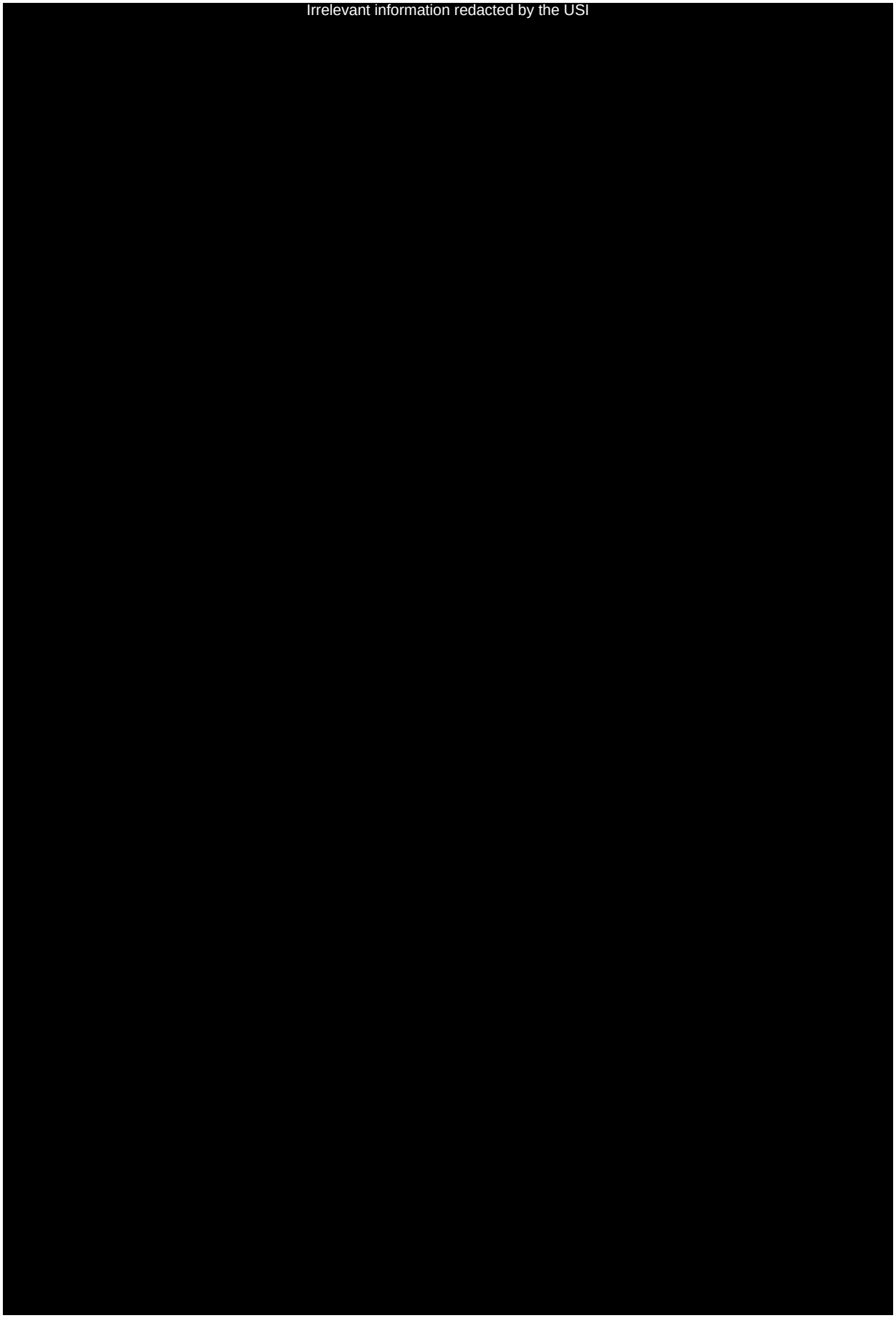

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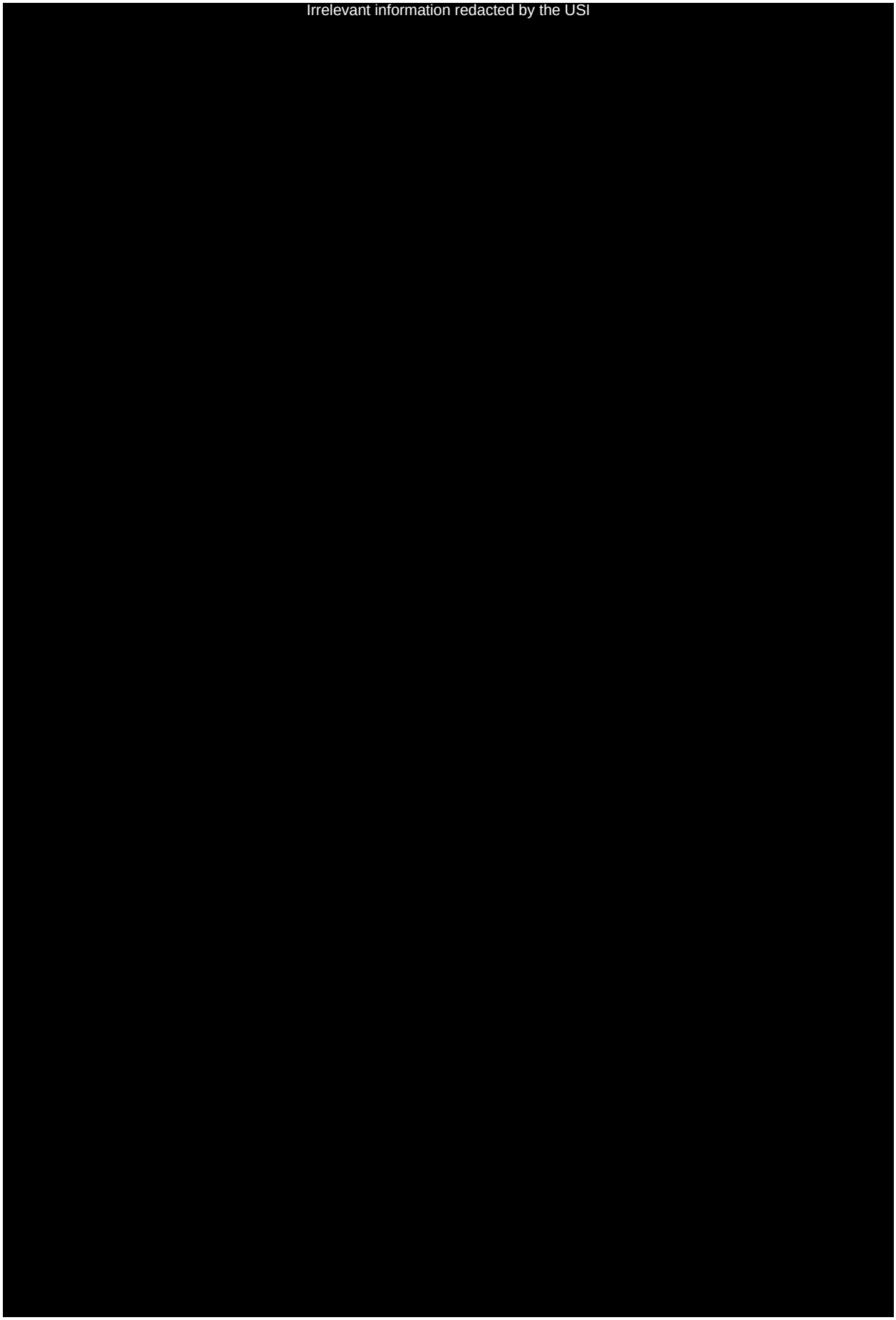

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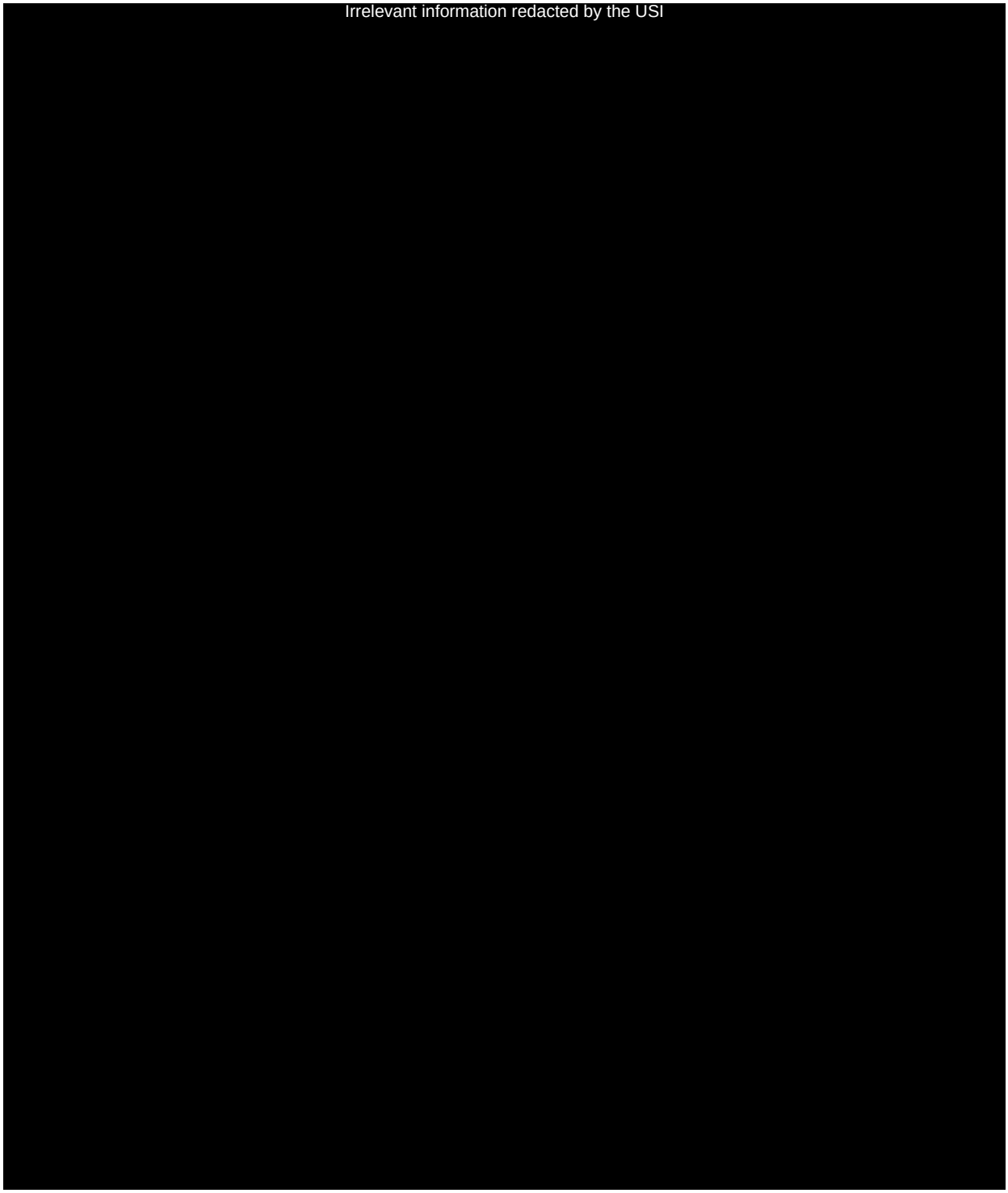

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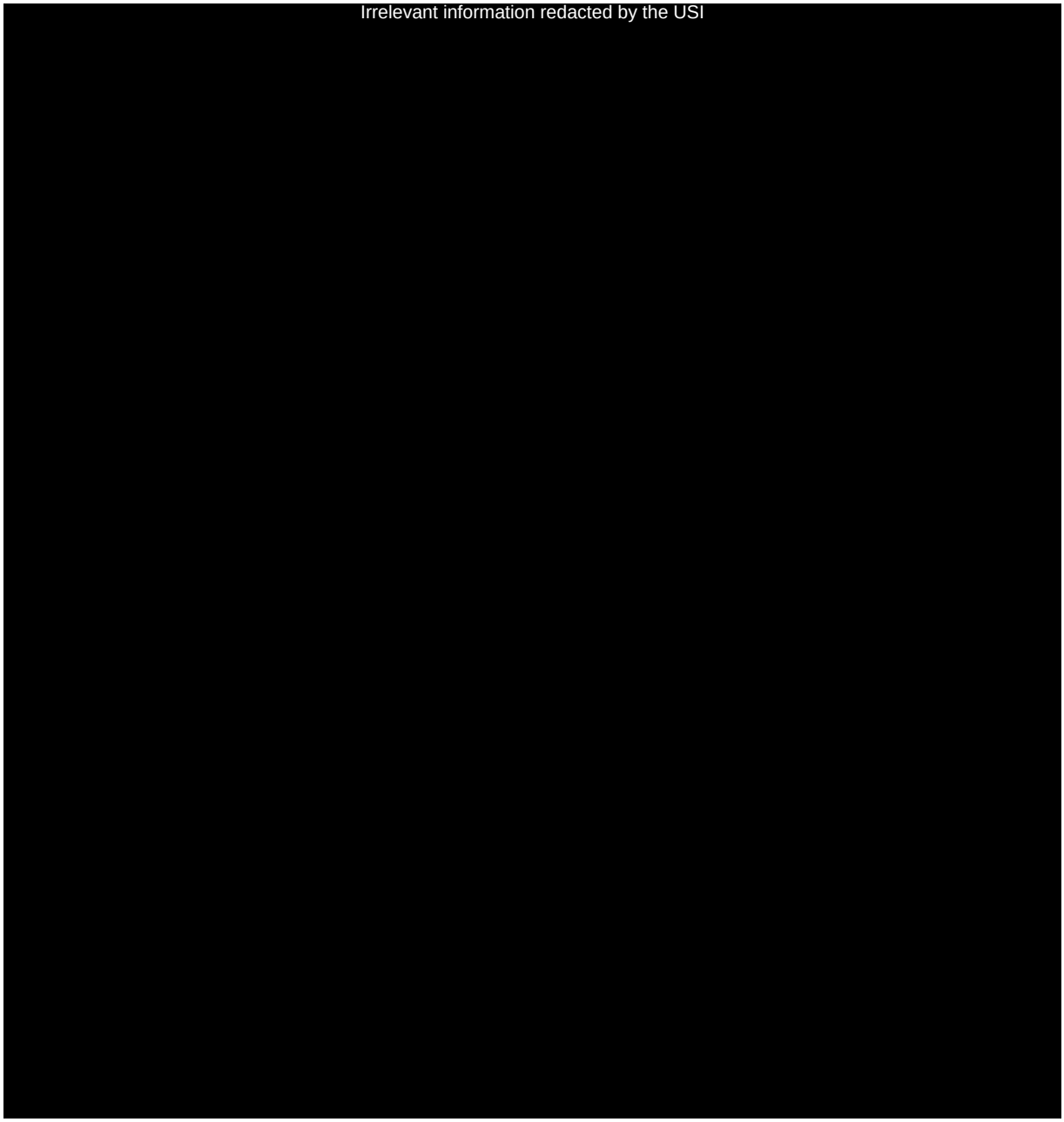


Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

HR Directors Forum

10 February 2020

D2 Conference Room, Castle Buildings

Attendees

DoH:
Andrew Dawson (Chair)
Chris Wilkinson
John Grills

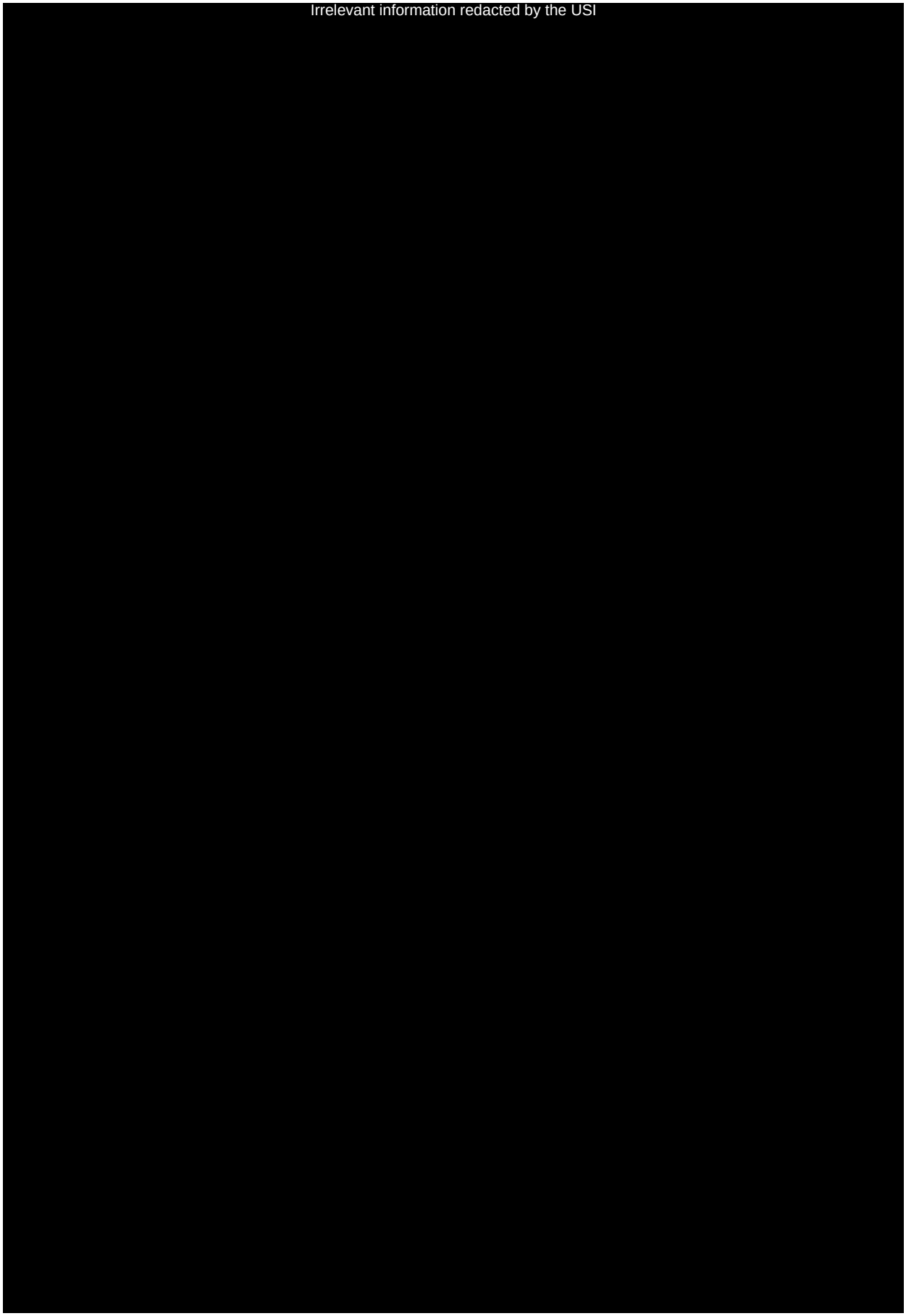
HSC:
Jacqui Kennedy BHSCT
Paula Smyth BSO
Vivienne Toal SHSCT
Myra Weir SEHSCT
Karen Hargan NHSCT
Ivan Ritchie BTS
Ann McConnell WHSCT (By Tele Call)

1.	**Welcome and apologies**
	Andrew welcomed everyone to the meeting. An apology was received from Michelle Lemon.
2.	**Minutes from Previous Meeting**
	The minutes from the previous meeting in January will be agreed via correspondence.
3.	**Action Log**

Irrelevant information redacted by the USI

[redacted]

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



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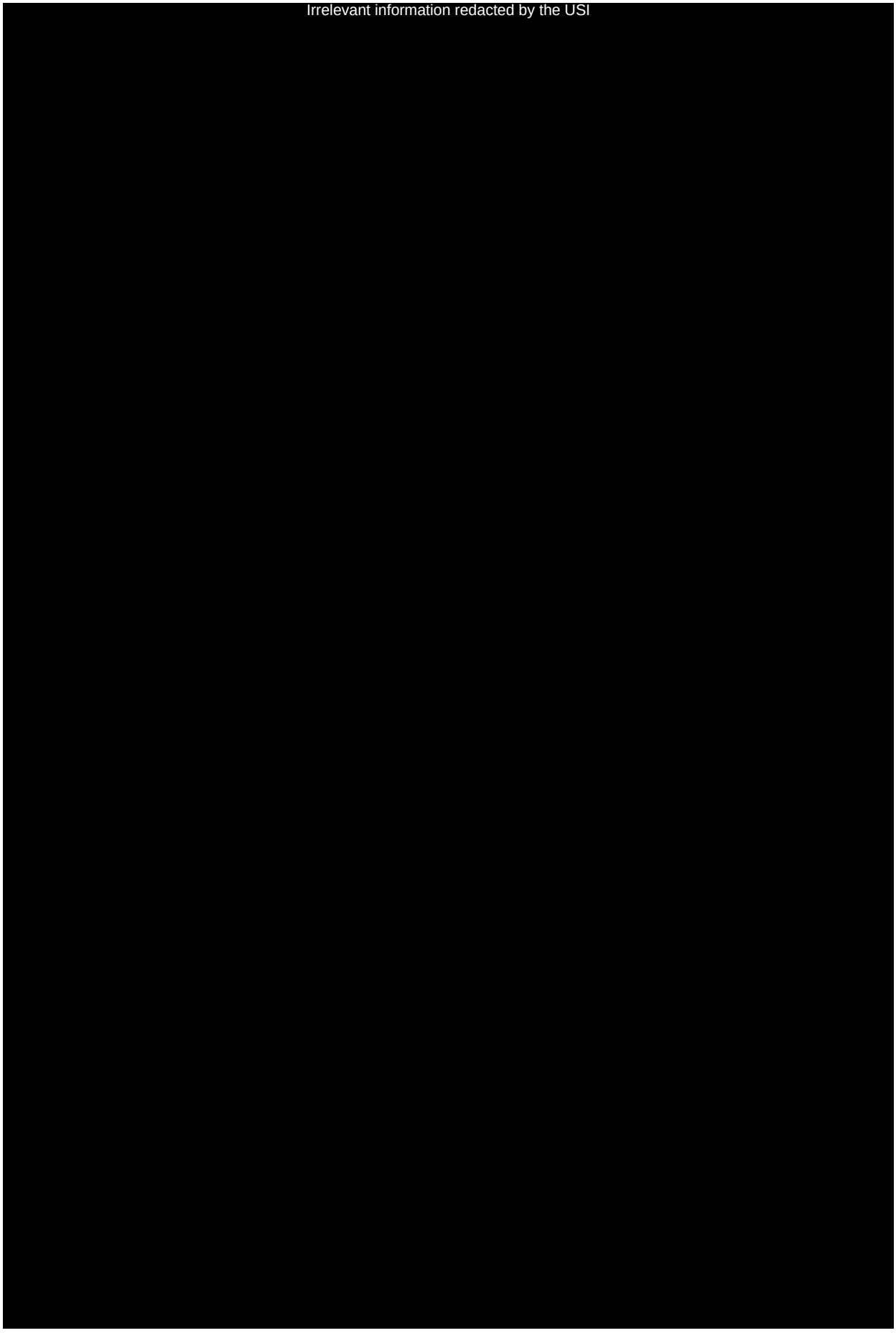

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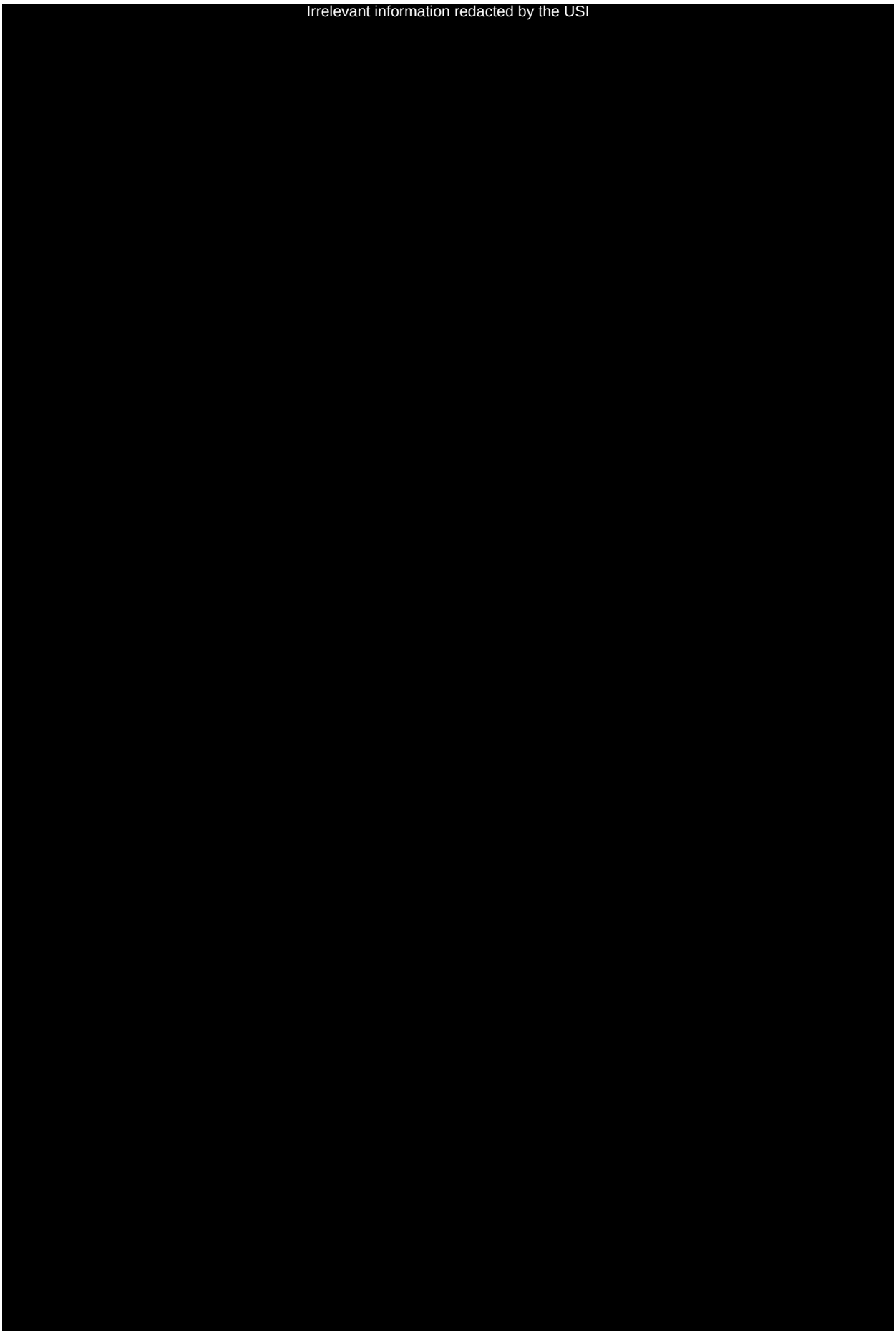

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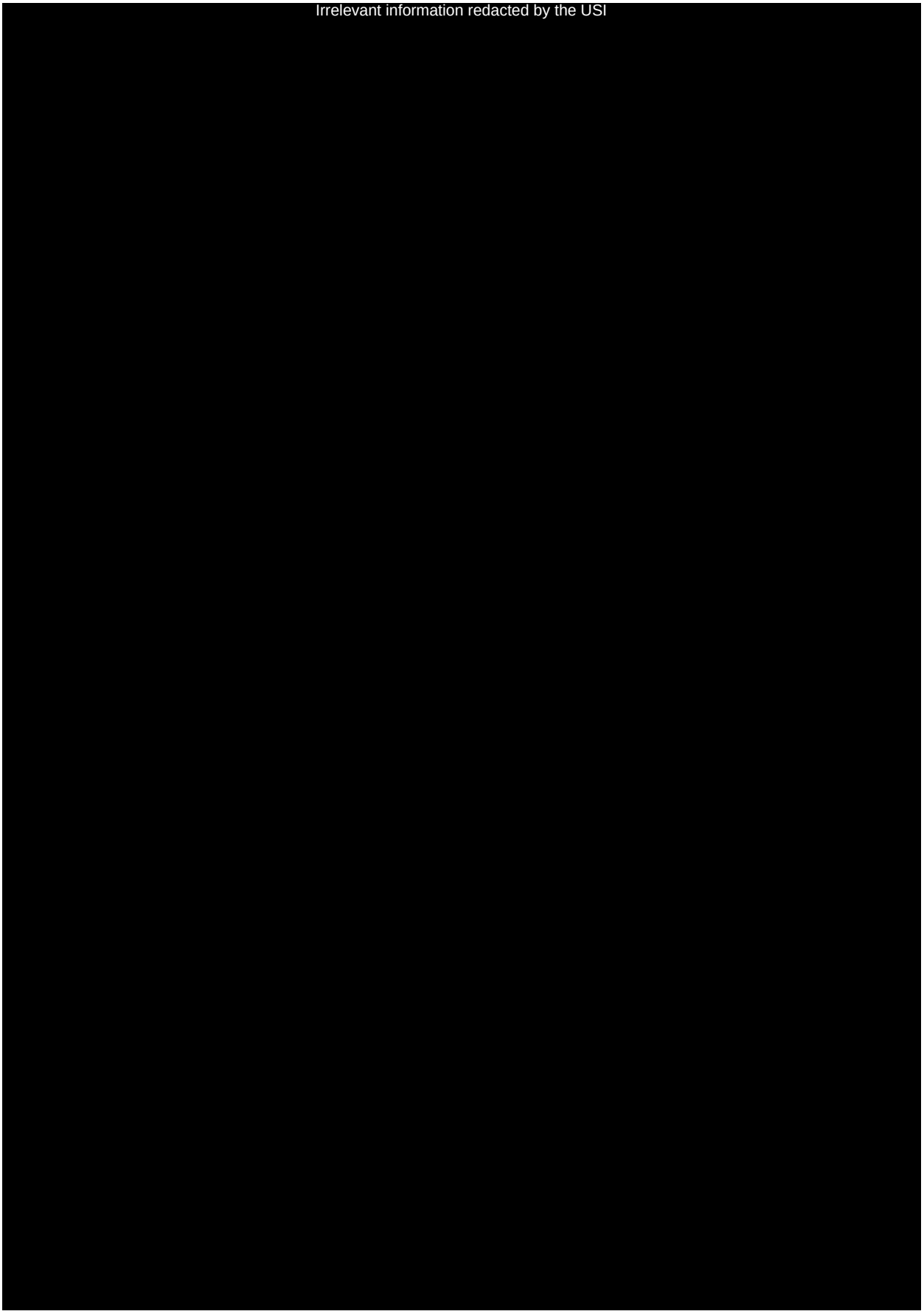

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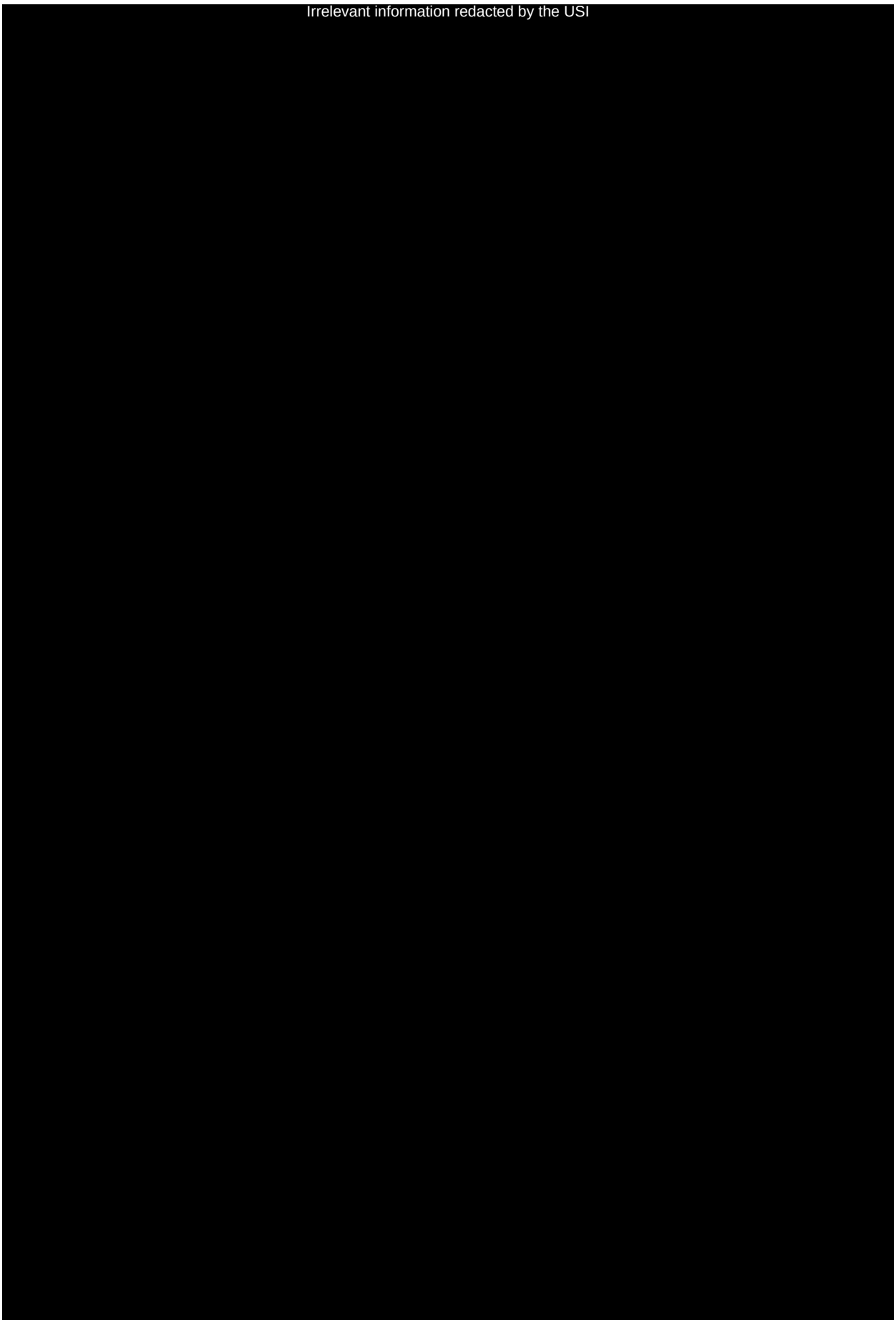

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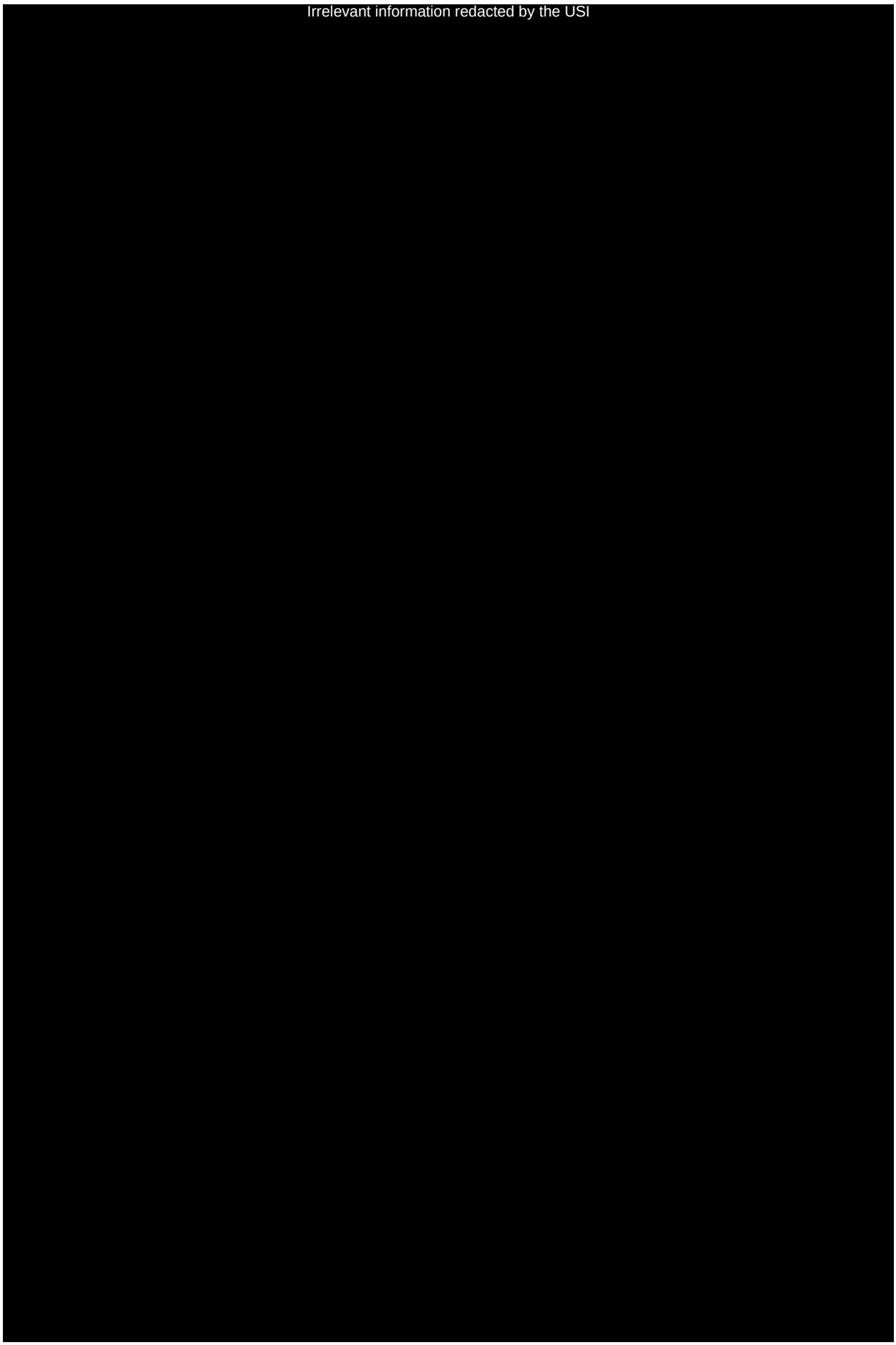

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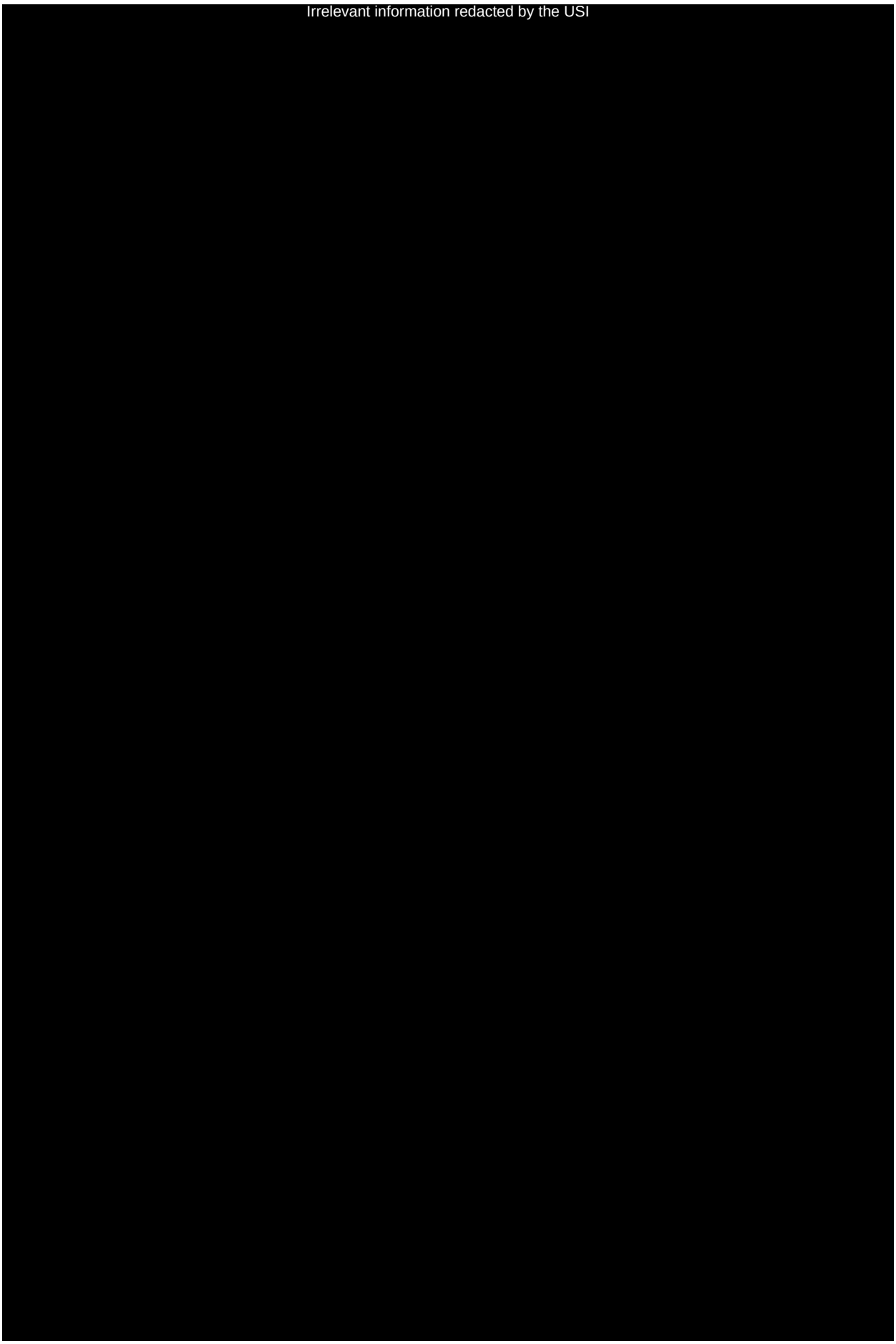

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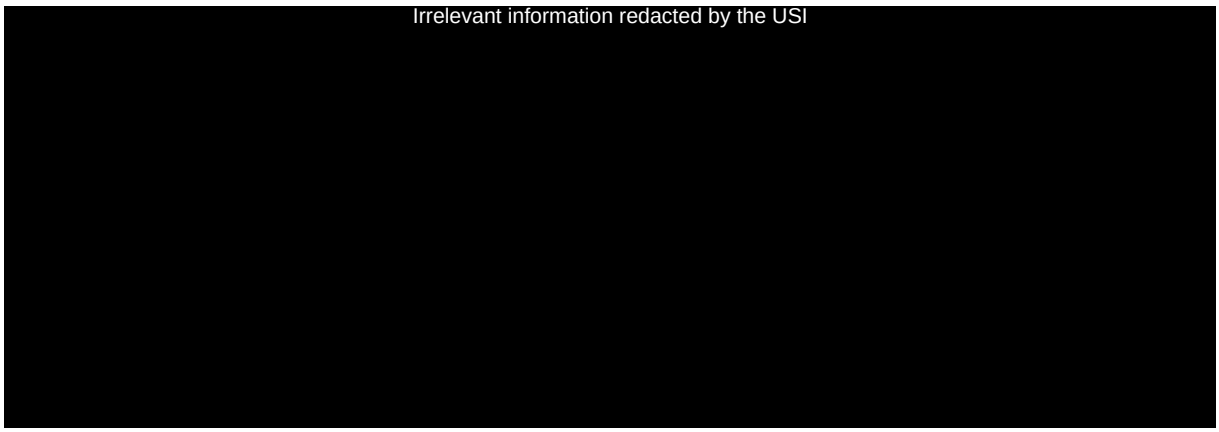

Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

Roberts, Naomi

From: Jeffrey, Karen
Sent: 10 December 2018 14:17
To: McGeown, Paula (DoH)
Cc: Godfrey, Brian (DoH); Magowan, Richard (DoH)
Subject: Section 75 query - Personal information redacted by USI

Paula

I have received a query from Personal Information redacted by USI regarding collection of Section 75 data – which I have answered. He has now responded asking for the screening carried out for Maintaining Higher Professional Standards Investigations, as he believes this policy was introduced after 1998.

I believe he is referring to the 'Maintaining High Professional Standards Policy'. I note from TRIM that Marc Bailie was taking forward a review of this in April 2018. I have spoken to our Equality Unit and they have no record of a screening for this policy – which is not unusual for that timeframe (see email below).

Can you confirm that you are content to take this query and respond to Personal Information redacted by USI directly?

Happy to discuss

Regards

Karen

Karen Jeffrey
Safety Policy Branch
Castle Buildings
Personal Information redacted by the USI

From: Tener, Judith
Sent: 10 December 2018 10:38
To: Jeffrey, Karen Personal Information redacted by the USI
Cc: Godfrey, Brian (DoH) Personal Information redacted by the USI; Floyd, Lisa Personal Information redacted by the USI; Patterson, Wendy Personal Information redacted by the USI
Subject: FW: Section 75

Karen

The NI Act came into operation in 1998, including Section 75 requirements to consider possible impact on the nine specified equality groups. As such, a screening should have been carried out (although it may not resemble the detailed screening template we currently use).

From Lisa's recollection the publication of screenings only came in around 2010 (or later) so Equality Unit (which may not have existed in 2005) would not have any records.

It would be a matter for the relevant policy area to check their records – although, presumably, it may be the case that, even if a screening was done it may have since been destroyed under the Department's Disposal schedule? (not sure if/ who keeps records or retention periods for this policy – IMB should be able to help if required).

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

Regarding FOI – IMB would need to advise but we have had previous requests for screenings and simply responded with a copy/ or that haven't been carried out and given reasons. There would not be an FOI exemption as we routinely publish screenings.

Happy to discuss.

Judith
Ext [redacted]

From: Jeffrey, Karen
Sent: 10 December 2018 09:55
To: Tener, Judith [redacted]; Floyd, Lisa [redacted]
Cc: Godfrey, Brian (DoH) [redacted]
Subject: FW: Section 75

Judith/Lisa

This is the case I was walking to Judith about on Friday – [redacted] initially queried our collection of Section 75 data for HSC staff who are referred to the PPA (NCAS) service. My reply to him is below. He has now asked for the screening on the Maintaining Higher Professional Standards policy. I have looked this up on TRIM and it is originally a policy from 2005. It appears to be being updated at the present. Should this request be handled as an FOI? And would you know if a screening was completed/was appropriate at this time?

Thanks

Karen

-----Original Message-----
From: [redacted]
Sent: 07 December 2018 15:46
To: Jeffrey, Karen [redacted]
Subject: Re: Section 75

That's great thanks. Can you forward me the screening carried out for Maintaining Higher Professional Standards Investigations as I believe this policy was introduced after 1998.

[redacted]

Sent from my iPhone

> On 7 Dec 2018, at 15:28, Jeffrey, Karen [redacted] wrote:
>
> Mr [redacted]
>
> Thanks for your email. I can confirm that the Department of Health NI (DoH NI) has a service level agreement in place with the Practitioner Performance Advice Service (which is part of NHS Resolution) to allow HSC bodies to avail of the services of the PPA Service in Northern Ireland. As a government department, the DoH NI is required to screen new policies and strategies against Section 75 however there is no requirement on PPA to collect Section 75 data on clients referred to the PPA service by their employing HSC body. I can confirm that Section 75 was discussed at the Annual SLA review meeting between PPA and DoH NI on Thursday 18th October when it was agreed that the current position would remain unchanged however to be kept under review if it was thought that the collection of such data

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

would provide added value to the PPA service.
>
> Regards
>
> Karen
>
> Karen Jeffrey
> Safety Policy Branch
> Castle Buildings
> [redacted]
>
>
> -----Original Message-----
From: [redacted]
> Sent: 07 December 2018 11:43
> To: Jeffrey, Karen [redacted]
> Subject: Section 75
>
>
> Hi Karen
>
Thank you for taking the time to speak to me today. I would be grateful if you would confirm that the Department of Health NI uses the services of NHS Resolution, that these services are based in Northern Ireland and that there is no Section 75 policy currently in place with regard to theses services. You also stated that Dr Colin Fitzpatrick met with Dr Paddy Woods on 17th October 2018 and that this matter was raised.
>
> [redacted]
>
>
> Sent from my iPhone

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

Roberts, Naomi

From: Hynes, Liz
Sent: 18 December 2018 13:03
To: McGeown, Paula (DoH)
Subject: RE: Section 75 query - [redacted]

I would assume so.

Liz

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: [redacted]
email: [redacted]
email: [redacted]
Mobile: [redacted]

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

From: McGeown, Paula (DoH)
Sent: 18 December 2018 1:02 PM
To: Hynes, Liz [redacted]
Subject: RE: Section 75 query - [redacted]

OK thanks so screening will take place in due course?

From: Hynes, Liz
Sent: 18 December 2018 1:00 PM
To: McGeown, Paula (DoH) <[redacted]
Subject: RE: Section 75 query - [redacted]

I am in conjunction with HR directors and Medical directors and Paddy Woods

Liz

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: [redacted]
email: [redacted]
email: [redacted]
Mobile: [redacted]

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

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

From: McGeown, Paula (DoH)
Sent: 18 December 2018 12:57 PM
To: Hynes, Liz [redacted]
Subject: RE: Section 75 query - [redacted]

Thanks Liz who's doing this?

From: Hynes, Liz
Sent: 18 December 2018 12:56 PM
To: McGeown, Paula (DoH) [redacted]
Cc: Boyd, Sylvia [redacted] Jeffrey, Karen [redacted]
Subject: RE: Section 75 query - [redacted]

Paula

A review has not yet taken place, it is due to be reviewed by the end of March 2019.

Liz

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: [redacted]
email: [redacted]
email: [redacted]
Mobile: [redacted]

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

From: McGeown, Paula (DoH)
Sent: 18 December 2018 12:08 PM
To: Hynes, Liz [redacted]
Cc: Boyd, Sylvia [redacted] Jeffrey, Karen [redacted]
Subject: FW: Section 75 query - [redacted]

[redacted] High Professional Standards Policy'?

Paula

From: Jeffrey, Karen
Sent: 10 December 2018 2:17 PM
To: McGeown, Paula (DoH) [redacted]
Cc: Godfrey, Brian (DoH) [redacted]; Magowan, Richard (DoH) [redacted]
Subject: Section 75 query [redacted]

Paula

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

I have received a query from Mr [redacted] regarding collection of Section 75 data – which I have answered. He has now responded asking for the screening carried out for Maintaining Higher Professional Standards Investigations, as he believes this policy was introduced after 1998.

I believe he is referring to the 'Maintaining High Professional Standards Policy'. I note from TRIM that Marc Bailie was taking forward a review of this in April 2018. I have spoken to our Equality Unit and they have no record of a screening for this policy – which is not unusual for that timeframe (see email below).

Can you confirm that you are content to take this query and respond to [redacted] directly?

Happy to discuss

Regards

Karen

Karen Jeffrey
Safety Policy Branch
Castle Buildings
[redacted]

From: Tener, Judith
Sent: 10 December 2018 10:38
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Ext [redacted]

From: Jeffrey, Karen
Sent: 10 December 2018 09:55
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Received from Peter May on 19/08/2022. Annotated by the Urology Services Inquiry.

Cc: Godfrey, Brian (DoH) [redacted]
Subject: FW: Section 75

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Thanks

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Sent from my iPhone

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>
> Regards
>
> Karen
>
> Karen Jeffrey
> Safety Policy Branch
> Castle Buildings
> [redacted]
>

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

>
> -----Original Message-----
> From: [redacted] Personal Information redacted by USI [redacted]
> Sent: 07 December 2018 11:43
> To: Jeffrey, Karen [redacted] Personal Information redacted by the USI
> Subject: Section 75
>
>
> Hi Karen
>
> Thank you for taking the time to speak to me today. I would be grateful if you would confirm that the Department of Health NI uses the services of NHS Resolution, that these services are based in Northern Ireland and that there is no Section 75 policy currently in place with regard to theses services. You also stated that Dr Colin Fitzpatrick met with Dr Paddy Woods on 17th October 2018 and that this matter was raised.
>
> [redacted] Personal Information redacted by USI
>
>
> Sent from my iPhone

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

Roberts, Naomi

From: [redacted] Personal information redacted by USI [redacted]
Sent: 18 December 2018 17:35
To: McGeown, Paula (DoH)
Subject: Re: Section 75 query - Personal information redacted by USI

Hi

Would you confirm that the Maintaining High Professional Standards Policy has never been screened? I would also be grateful if you would confirm when this review was first scheduled?

With regards to the screening data which is collated, would you be able to confirm that this data set is the one used for screening in the rest of the U.K. rather than a Northern Ireland specific one?

Cheers

[redacted]

On 18 Dec 2018, at 16:48, McGeown, Paula (DoH) Personal information redacted by USI [redacted] wrote:

[redacted]

I wish to advise that a review of 'Maintaining High Professional Standards Policy' has not yet taken place, it is due to be reviewed by the end of March 2019. Screening, therefore, has yet to be done.

I hope this is helpful

Paula
Pay & Employment
Workforce Policy Directorate
Personal Information [redacted]

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

Roberts, Naomi

From: McGeown, Paula (DoH)
Sent: 18 December 2018 16:48
To: [redacted]
Cc: Jeffrey, Karen; 'Liz Hynes'
Subject: FW: Section 75 query - [Personal information redacted by USI]

[redacted]

I wish to advise that a review of 'Maintaining High Professional Standards Policy' has not yet taken place, it is due to be reviewed by the end of March 2019. Screening, therefore, has yet to be done.

I hope this is helpful

Paula
Pay & Employment
Workforce Policy Directorate
[Personal Information redacted]

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

Roberts, Naomi

From: Hynes, Liz
Sent: 19 December 2018 14:03
To: [redacted]
Cc: McGeown, Paula (DoH)
Subject: RE: Section 75 query - [Personal Information redacted by USI]

[redacted]

Your enquiry has been sent to me for a response.

Unfortunately I am unable to provide a definitive response at this time, as a key person is currently out of the office until Friday. I will upon their return to the office, chase up the information you have requested.

Apologies for the delay.

Liz

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: [Personal Information redacted by the USI]
email: [Personal Information redacted by the USI]
email [Personal Information redacted by the USI]
Mobile: [Personal Information redacted by the USI]

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

From: [redacted] [Personal information redacted by USI]
Sent: 18 December 2018 5:35 PM
To: McGeown, Paula (DoH) [Personal Information redacted by the USI]
Subject: Re: Section 75 query - [Personal information redacted by USI]

Hi

Would you confirm that the Maintaining High Professional Standards Policy has never been screened? I would also be grateful if you would confirm when this review was first scheduled?

With regards to the screening data which is collated, would you be able to confirm that this data set is the one used for screening in the rest of the U.K. rather than a Northern Ireland specific one?

Cheers

[redacted]

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[redacted]

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I hope this is helpful

Paula
Pay & Employment
Workforce Policy Directorate
[redacted]

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

Roberts, Naomi

From: Hynes, Liz
Sent: 19 December 2018 11:10
To: McGeown, Paula (DoH)
Subject: RE: Section 75 query - [redacted]

Paula

I will need to check with Paddy Woods, for Q1 and the equality section for the second part of the Q.

Liz

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: [redacted]
email: [redacted]
email: [redacted]
Mobile: [redacted]

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

From: McGeown, Paula (DoH)
Sent: 19 December 2018 10:04 AM
To: Hynes, Liz [redacted]
Subject: FW: Section 75 query - [redacted]

Liz – grateful if you could advise [redacted]

Thanks
Paula

From: [redacted]
Sent: 18 December 2018 5:35 PM
To: McGeown, Paula (DoH) [redacted]
Subject: Re: Section 75 query - [redacted]

Hi

Would you confirm that the Maintaining High Professional Standards Policy has never been screened? I would also be grateful if you would confirm when this review was first scheduled?

With regards to the screening data which is collated, would you be able to confirm that this data set is the one used for screening in the rest of the U.K. rather than a Northern Ireland specific one?

Cheers

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[redacted]

On 18 Dec 2018, at 16:48, McGeown, Paula (DoH) [redacted] wrote:

[redacted]

I wish to advise that a review of 'Maintaining High Professional Standards Policy' has not yet taken place, it is due to be reviewed by the end of March 2019. Screening, therefore, has yet to be done.

I hope this is helpful

Paula
Pay & Employment
Workforce Policy Directorate
[redacted]

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

Roberts, Naomi

From: Dawson, Andrew
Sent: 01 February 2019 15:05
To: Spence, Doreen
Subject: FW: [WARNING: MESSAGE ENCRYPTED]FW: CONFIDENTIAL - 3 month review of MHPS Exclusion of a Doctor [UNSCANNED] [UNSCANNED]
Attachments: Email to [redacted] 29-11-18.zip

D

Very grateful if you could contact Angela for the password and also if you could print docs when available.

Many thanks.

A

From: Muldoon, Angela [redacted]
Sent: 03 January 2019 11:16
To: Dawson, Andrew [redacted]
Cc: Wallace, Doreen [redacted]; Austin, Stephen [redacted]; Watson, Peter [redacted]; Boyd, Lynda [redacted]; Kelly, SharonA [redacted]
Subject: [WARNING: MESSAGE ENCRYPTED]FW: CONFIDENTIAL - 3 month review of MHPS Exclusion of a Doctor [UNSCANNED]

[redacted]

Good Morning Andrew

Please find attached correspondence for your attention.

I have encrypted the documents and would appreciate if your office could contact me for the password, [redacted].

Many Thanks

Angela Muldoon
on behalf of Martin Dillon

From: Austin, Stephen [redacted]
Sent: 20 December 2018 14:43
To: Dillon, Martin [redacted]
Cc: Kennedy, Jacqui [redacted]; 'Keith Gardiner' [redacted]; Watson, Peter [redacted]; Boyd, Lynda [redacted]
Subject: CONFIDENTIAL - 3 month review of MHPS Exclusion of a Doctor

Dear Martin,

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

I am writing to you at this time in accordance with Section II paragraph 28 of Maintaining High Professional Standards in the Modern HPSS (MHPS). I enclose a copy of MHPS for your convenience.
I also enclose key details in relation to the management of the case of [redacted], who has now been excluded for three months, and whose exclusion must be reviewed as outlined in MHPS.

I can confirm that this letter and the key details attached have been shared with Ms Karen Wadman of NCAS, and Mrs Jacqui Kennedy, Director of Human Resources and Organisational Development, and they have confirmed the appropriateness of the continued exclusion. The approach has also been discussed with Professor Keith Gardiner of NIMDTA who is the doctor's Responsible Officer. The basis for the continuing exclusion remains as outlined in the letters of 4 October, 12 October and 29 November 2018.

An investigation has not yet been initiated at the Trust, pending the completion of the PSNI consideration of these matters, which you will note is expected to take some time, and with a bail review not scheduled to take place until March 2019. It is therefore not possible for us to provide a date for the completion of the Trust investigation.

I would ask that you now in accordance with MHPS forward this correspondence and the attached details to the Director of Human Resources at the Department of Health, who will involve the Chief Medical Officer if appropriate. The approval of the Department of Health to the approach being followed should be sought at this time.

Should you have any queries in relation to this matter I will be happy to address these.

Yours sincerely,

Stephen

Dr Stephen Austin MB BCh BSc MPhil FCARCSI FRCA DICM FFICM
Deputy Medical Director (Education and Workforce)
Belfast HSC Trust
Personal Information redacted by the USI
Personal Information redacted by the USI

Personal inform – printing – filing - [redacted]

This message contains information from Belfast Health And Social Care Trust which may be privileged and confidential.
If you believe you are not the intended recipient any disclosure, distribution or use of the contents is prohibited.
If you have received this message in error please notify the sender immediately.

This email has been scanned for the presence of computer viruses.

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

Roberts, Naomi

From: Spence, Doreen
Sent: 07 February 2019 16:34
To: Belfast Trust - Martin Dillon; Muldoon, Angela
Cc: stephen.austin[redacted] peter.watson[redacted] lynda.boyd[redacted] PA - Dr Jack (Sharon Kelly); McBride, Michael; Carson, Jane; Dawson, Andrew
Subject: CONFIDENTIAL - 3 month review of MHPS Exclusion of a Doctor [UNSCANNED] [UNSCANNED]
Attachments: Document1.docx

Colleagues

Please see the above correspondence from Andrew Dawson

Please note that password remains as previously set.

Many thanks

Doreen Wallace

Doreen Wallace
PS/Andrew Dawson - Director of Workforce Policy, Healthcare Policy Group; &
PS/Brigitte Worth - Investment Director, Resource & Performance Management Group
Department of Health
Room D4.13
Castle Buildings

Tel: [redacted]
E-Mail: [redacted]

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

Roberts, Naomi

From: Dawson, Andrew
Sent: 26 November 2019 12:26
To: Muldoon, Angela
Cc: Spence, Doreen
Subject: FW: [WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED][WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED]FW: CONFIDENTIAL : MHPS Review of a case by the Department of Health [UNSCANNED] [UNSCANNED]
Attachments: hrd_suspensions_framework.pdf; Letter to Personal information redacted by USI (003).zip

Angela

Many thanks for your email and apologies for the delay in responding.

I have now had time to thoroughly consider the papers in full for the purposes of a six month review.

The Department continues to approve of the approach being followed in this case.

Kind regards,

Andrew

Andrew Dawson
Director, Workforce Policy
Department of Health NI | D4.11 Castle Buildings | Stormont | Belfast | BT4 3SQ | Personal Information redacted by the USI | Personal Information redacted by the USI

From: Wallace, Doreen
Sent: 26 November 2019 09:35
To: Dawson, Andrew Personal Information redacted by the USI
Subject: FW: [WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED][WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED]FW: CONFIDENTIAL : MHPS Review of a case by the Department of Health [UNSCANNED]

From: Muldoon, Angela Personal Information redacted by the USI
Sent: 25 November 2019 10:44
To: Wallace, Doreen Personal Information redacted by the USI
Subject: [WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED][WARNING : MESSAGE ENCRYPTED, NOT VIRUS SCANNED]FW: CONFIDENTIAL : MHPS Review of a case by the Department of Health [UNSCANNED]

Good Morning Doreen

Can you please advise if Andrew has any response to the attached.

Password already advised.

Many Thanks

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

Angela

From: Muldoon, Angela
Sent: 30 October 2019 15:39
To: Dawson, Andrew [redacted]
Cc: Wallace, Doreen [redacted]; Austin, Stephen [redacted]
Subject: FW: CONFIDENTIAL : MHPS Review of a case by the Department of Health

Good Afternoon Andrew

Please find attached correspondence for your attention, I have encrypted the document and will send the password in a separate e-mail.

Many Thanks

Angela Muldoon
on behalf of Martin Dillon

From: Austin, Stephen [redacted]
Sent: 28 October 2019 15:11
To: Dillon, Martin [redacted]
Subject: CONFIDENTIAL : MHPS Review of a case by the Department of Health

Dear Martin,

I am writing to you at this time in accordance with Section II paragraph 28 and 29 of Maintaining High Professional Standards in the Modern HPSS (MHPS). I enclose a copy of MHPS for your convenience.
I also enclose key details in relation to the management of the case of Dr [redacted], who has now been excluded since 26th September 2018, and whose exclusion must be reviewed as outlined in MHPS.

Dr [redacted] case has been reviewed on a monthly basis taking into account information received by the Trust that the police investigation continues, and that the doctor has been re-bailed on a number of occasions pending completion of this investigation. As of the date of this email, it is the Trust's understanding that the police investigation remains ongoing. Taking account of the seriousness of the allegations, and the GMC conditions which remain on the practice of Dr [redacted], the Trust has concluded at the time of each monthly review, that the exclusion from work of Dr [redacted] continues to be appropriate.

Professor Keith Gardiner of NIMDTA, who is the doctor's Responsible Officer, has been kept updated on the need for continued exclusion. The basis for the continuing exclusion remains as outlined in the most recent letter of 23rd October 2019.

An investigation has not yet been initiated at the Trust, pending the completion of the PSNI consideration of these matters, which you will note is expected to take some further time. It is therefore not possible for us to provide a date for the completion of the Trust investigation.

On recent review of this case, I noted that whilst there have been monthly reviews of the exclusion and a review by the Department of Health at 3 months (which have been notified to Dr [redacted] and also to his Responsible Officer,

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

Professor Gardiner), there was not a 6 month review of the exclusion by the Department. Therefore, it is our view that the case should be reviewed by the Department of Health to confirm the continuing approach.

I have consulted with the Practitioner Advice Service (NCAS) to confirm this approach, who also noted that a 6 month review is required in Northern Ireland (but not in England).

I would ask that you now in accordance with MHPS forward this correspondence and the attached details to the Director of Human Resources at the Department of Health, who will involve the Chief Medical Officer if appropriate. The approval of the Department of Health to the approach being followed should be sought at this time.

Should you have any queries in relation to this matter I will be happy to address these.

Yours sincerely,

Stephen

Dr Stephen Austin MB BCh BSc MPhil FCARCSI FRCA DICM FFICM
Deputy Medical Director (Education and Workforce)
Belfast HSC Trust
Personal Information redacted by the USI
Personal Information redacted by the USI

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

Addendum to Maintaining High Professional Standards

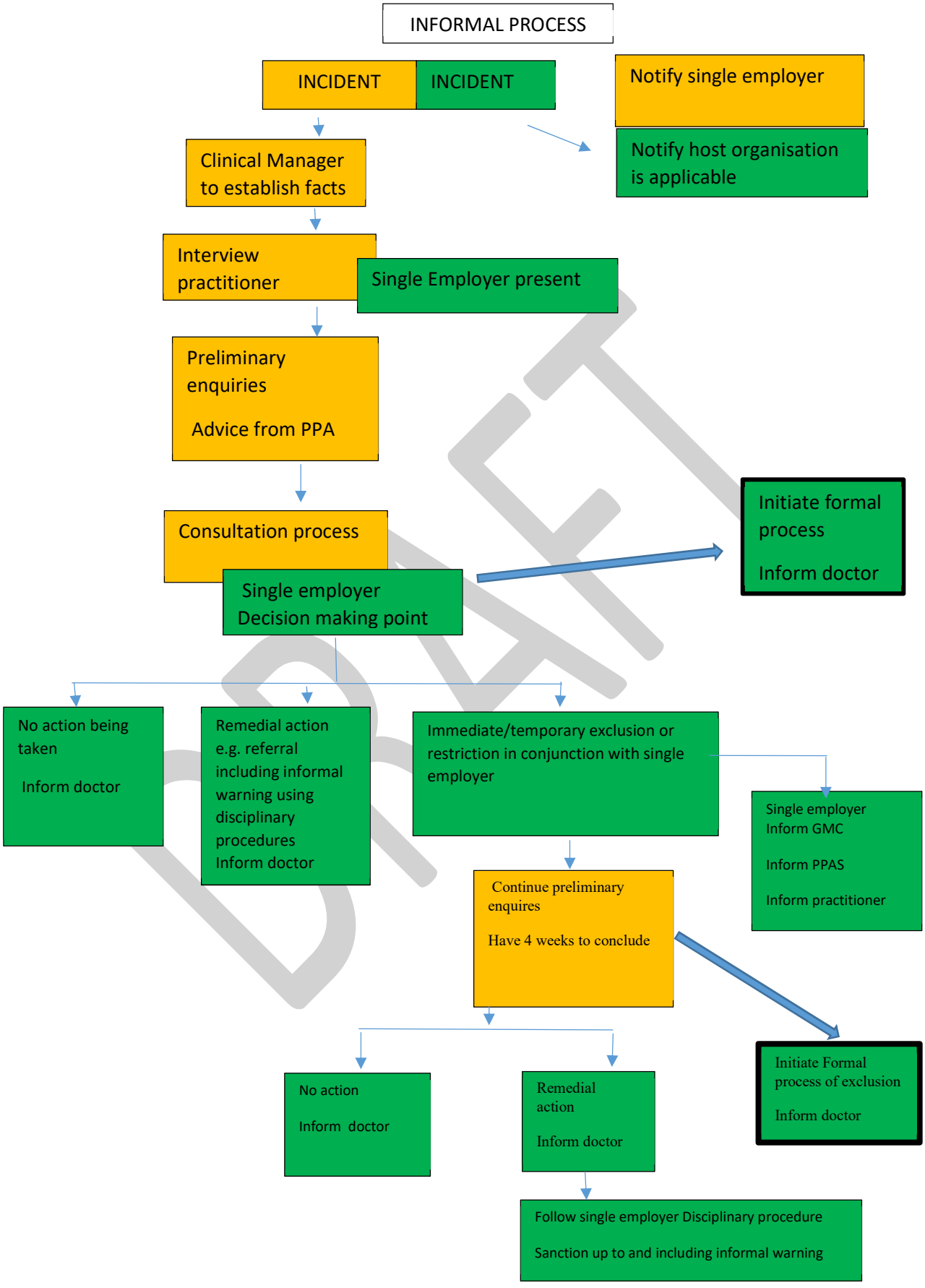
This addendum has been drawn up in collaboration and in partnership with NIMDTA, HSC Trusts and the BMA.

It does not change the way in which the MHPS policy works.

The flowchart has been designed to identify the roles and responsibilities of both the employing organisation and the host organisation under the Single Employer Model for Doctors and Dentists in Training.

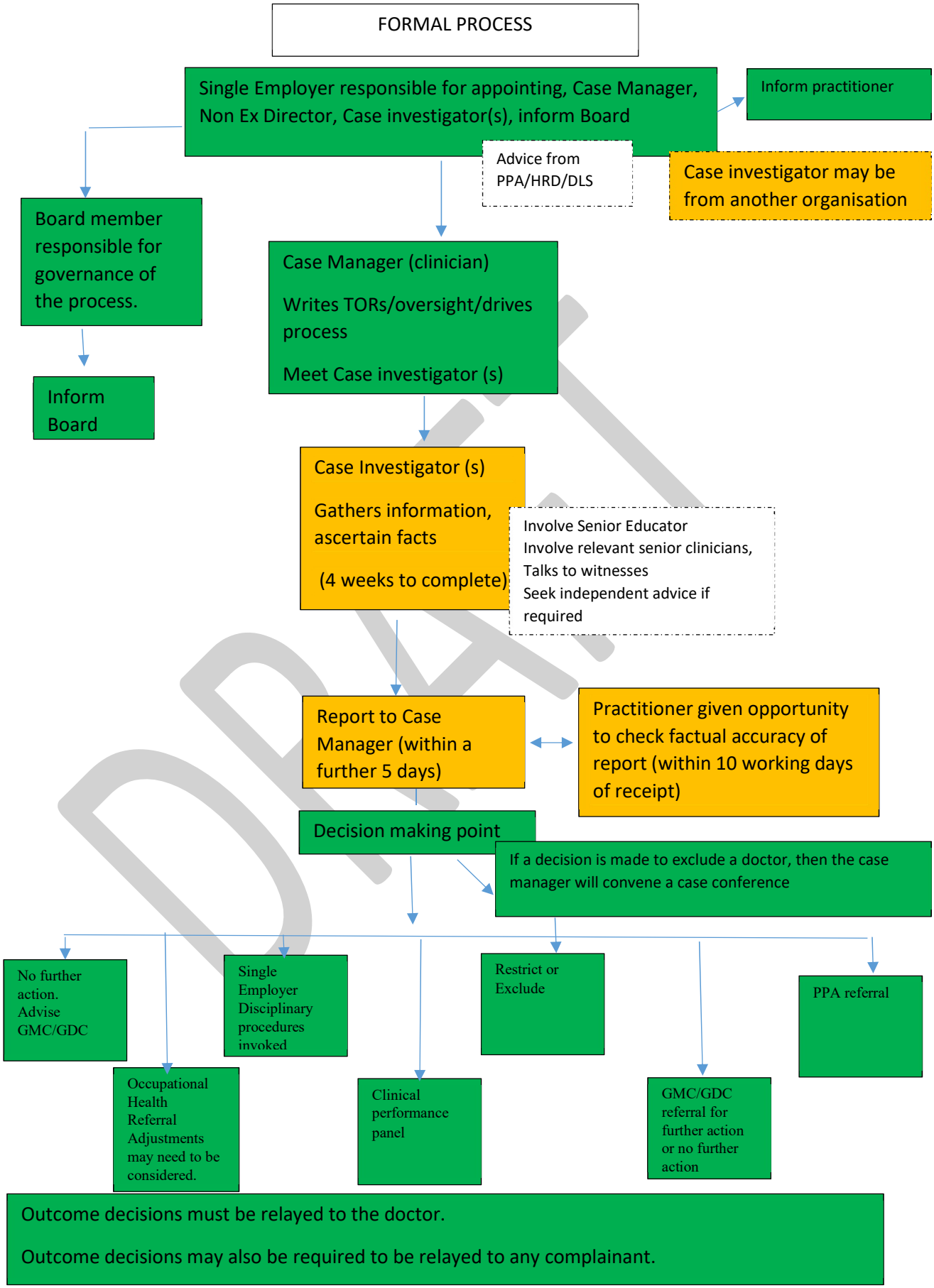
DRAFT

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



Employer is responsible for undertaking this action.
Host organisation may be asked to undertake duties on behalf of employing organisation

DRAFT


FORMAL PROCESS
Single Employer responsible for appointing, Case Manager, Non Ex Director, Case investigator(s), inform Board
Inform practitioner
Advice from PPA/HRD/DLS
Case investigator may be from another organisation
Board member responsible for governance of the process.
Inform Board
Case Manager (clinician)
Writes TORs/oversight/drives process
Meet Case investigator (s)
Case Investigator (s)
Gathers information, ascertain facts
(4 weeks to complete)
Involve Senior Educator
Involve relevant senior clinicians,
Talks to witnesses
Seek independent advice if required
Report to Case Manager (within a further 5 days)
Practitioner given opportunity to check factual accuracy of report (within 10 working days of receipt)
Decision making point
If a decision is made to exclude a doctor, then the case manager will convene a case conference
No further action. Advise GMC/GDC
Occupational Health Referral Adjustments may need to be considered.
Single Employer Disciplinary procedures invoked
Clinical performance panel
Restrict or Exclude
GMC/GDC referral for further action or no further action
PPA referral
Outcome decisions must be relayed to the doctor.
Outcome decisions may also be required to be relayed to any complainant.
Employer is responsible for undertaking this action.
Host organisation may be asked to undertake duties on behalf of employing organisation

DRAFT

Roberts, Naomi

From: Keith Gardiner [redacted]
Sent: 28 May 2019 19:29
To: Charlie.Martyn [redacted] cathy.jack [redacted] Hughes Dermot [redacted] 'seamus.oreilly [redacted] OKane, Maria
Cc: Austin, Stephen; Denise Hughes; Ian Steele; Magill, Bob; peter.watson@[redacted] 'Tosh, Grainne'; Gibson, Simon; Hynes, Liz
Subject: FW: Single Employer Draft Documents for comment
Attachments: Draft addendum to MHPS - single employer model - DDiT.DOCX

"This email is covered by the disclaimer found at the end of the message."

Dear All
This addendum to MHPS with reference to doctors in training was mentioned today at the Single Employer Steering Group. Liz Hynes gave permission to share.
I have copied Liz into this email in case you want to make any comments
Keith

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

Addendum to Maintaining High Professional Standards

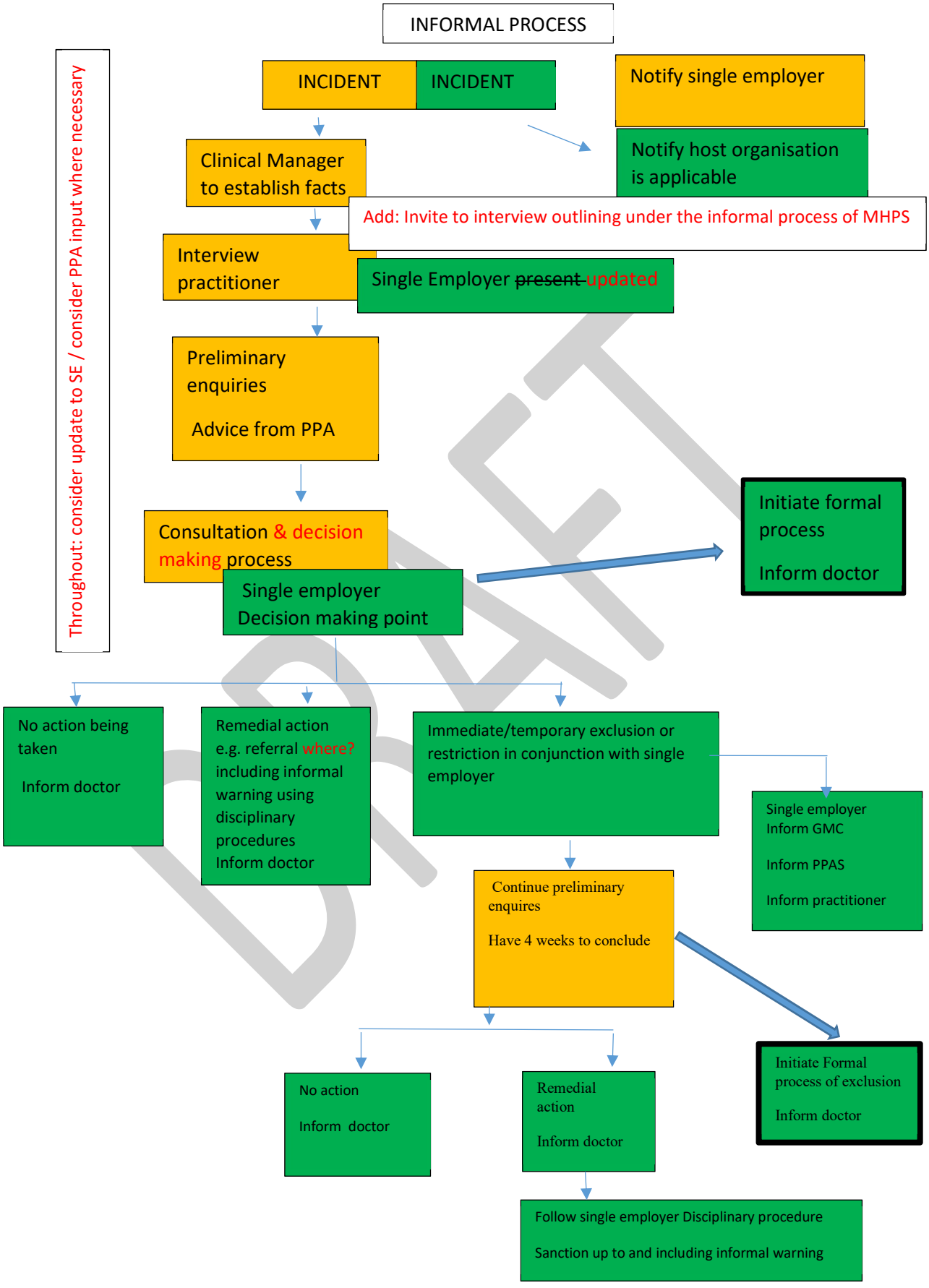
This addendum has been drawn up in collaboration and in partnership with NIMDTA, HSC Trusts and the BMA.

It does not change the way in which the MHPS policy works.

The flowchart has been designed to identify the roles and responsibilities of both the employing organisation and the host organisation under the Single Employer Model for Doctors and Dentists in Training.

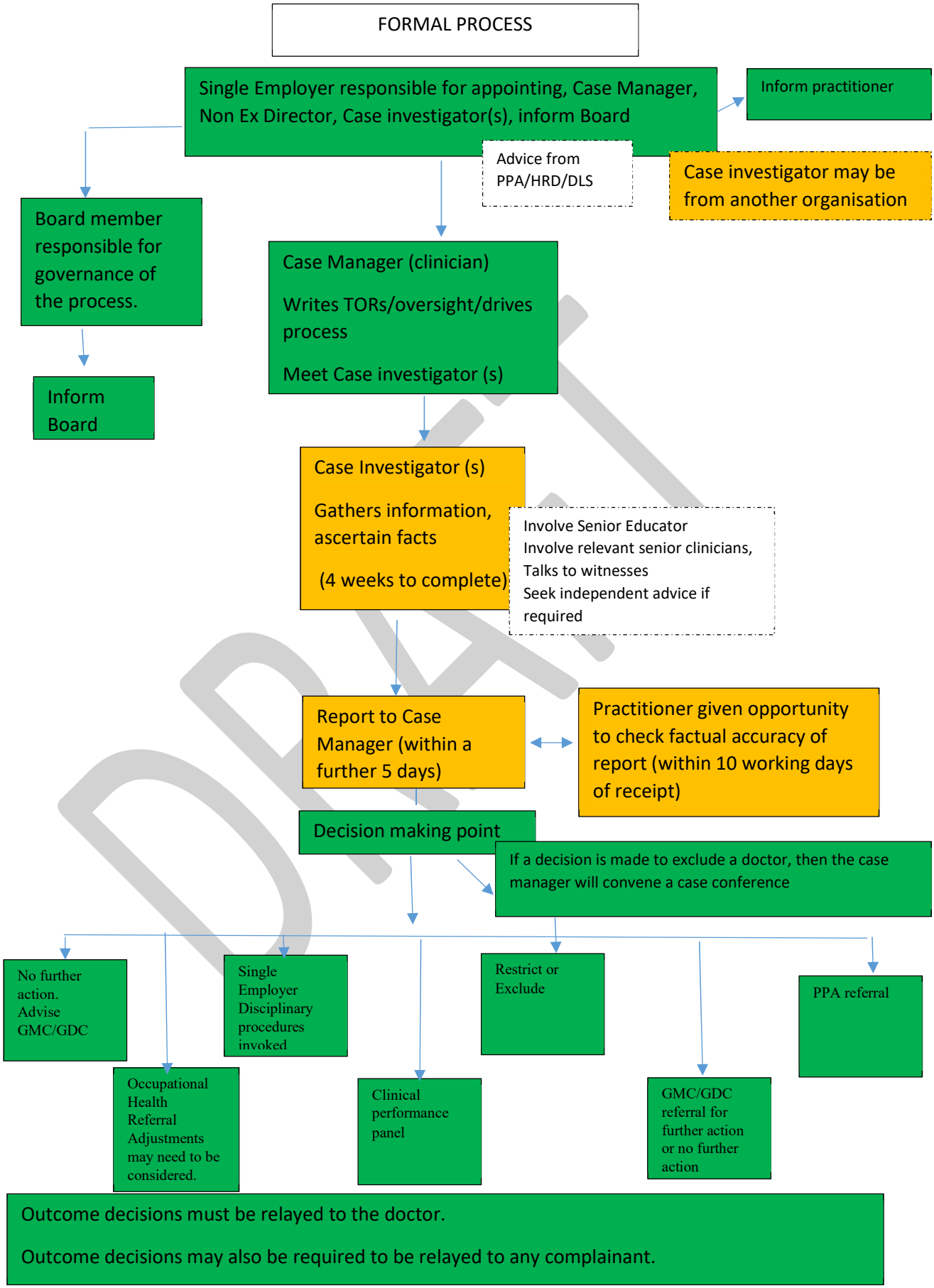
Low level incidents will continue to be managed at a local level when an incident arises which may include a pre-MHPS fact finding exercise to assess the severity. The host organisation will need to make a recommendation to the single employer if MHPS should be invoked. It is following this recommendation that the flow charts will be followed.

DRAFT



DRAFT

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



DRAFT

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

Roberts, Naomi

From: Denise Hughes [redacted]
Sent: 07 June 2019 08:09
To: Hynes, Liz; Boyd, Sylvia
Cc: Ian Steele; Keith Gardiner; Roisin Campbell
Subject: RE: Single Employer Draft Documents for comment: MHPS
Attachments: Draft addendum to MHPS - single employer model - DDiT nimdta comments.DOCX.docx

"This email is covered by the disclaimer found at the end of the message."

Liz
Please find attached comments on this draft flowchart – we discussed with the DMEs and also with Bob Magill.
It would be helpful to define the types of low level concerns and incidents which will continue to be managed at a local level as the threshold may vary across Trusts.
Thanks
Denise

From: Hynes, Liz [redacted]
Sent: 24 May 2019 17:03
To: Denise Hughes; Boyd, Sylvia
Cc: Ian Steele; Keith Gardiner; Roisin Campbell
Subject: RE: Single Employer Draft Documents for comment

The MHPS flowchart attached.

From: Denise Hughes [redacted]
Sent: 24 May 2019 17:00
To: Boyd, Sylvia [redacted]; Hynes, Liz [redacted]
Cc: Ian Steele [redacted]; Keith Gardiner [redacted]; Roisin Campbell [redacted]
Subject: RE: Single Employer Draft Documents for comment

"This email is covered by the disclaimer found at the end of the message."

Liz/Sylvia
We have reviewed the documents and provided some initial comments – this will require further work and it would be helpful to review in more detail, ideally as a group.
Do you have a draft flowchart or documentation in relation to the proposed revisions to MHPS which we had discussed at the workshop? We have a DME meeting next week and it would be useful to discuss to get their views when they are together as a group.
Thanks
Denise

From: Boyd, Sylvia [redacted]
Sent: 17 May 2019 14:05
To: Ruth Allen; Ian Steele; Denise Hughes; Jaclyn Crowe; Zoe Parks; Elaine O'Neill; Lucinda Wright; McAleer, Geraldine

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

Cc: Hynes, Liz
Subject: Single Employer Draft Documents for comment

All

Following on from the 2 day workshop last week could I ask you to have a look at the attached documents and make any comments you see fit.

If there are any typo's that is my fault and they can be changed before the documents are finalised.

If you could have them returned by Friday 24th May I would appreciate it.

Regards
Sylvia

Sylvia Boyd,
Pay and Employment Branch,
Department of Health Northern Ireland,
Room D1, Castle Buildings,
Stormont Estate,
Belfast ,
BT4 3SQ

Tel Personal Information redacted by the USI

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

Addendum to Maintaining High Professional Standards

This addendum has been drawn up in collaboration and in partnership with NIMDTA, HSC Trusts and the BMA.

It does not change the way in which the MHPS policy works.

The flowchart has been designed to identify the roles and responsibilities of both the employing organisation and the host organisation under the Single Employer Model for Doctors and Dentists in Training.

Low level incidents will continue to be managed at local level in Host Organisations which may include a fact finding exercise to assess the nature and severity of the incident.

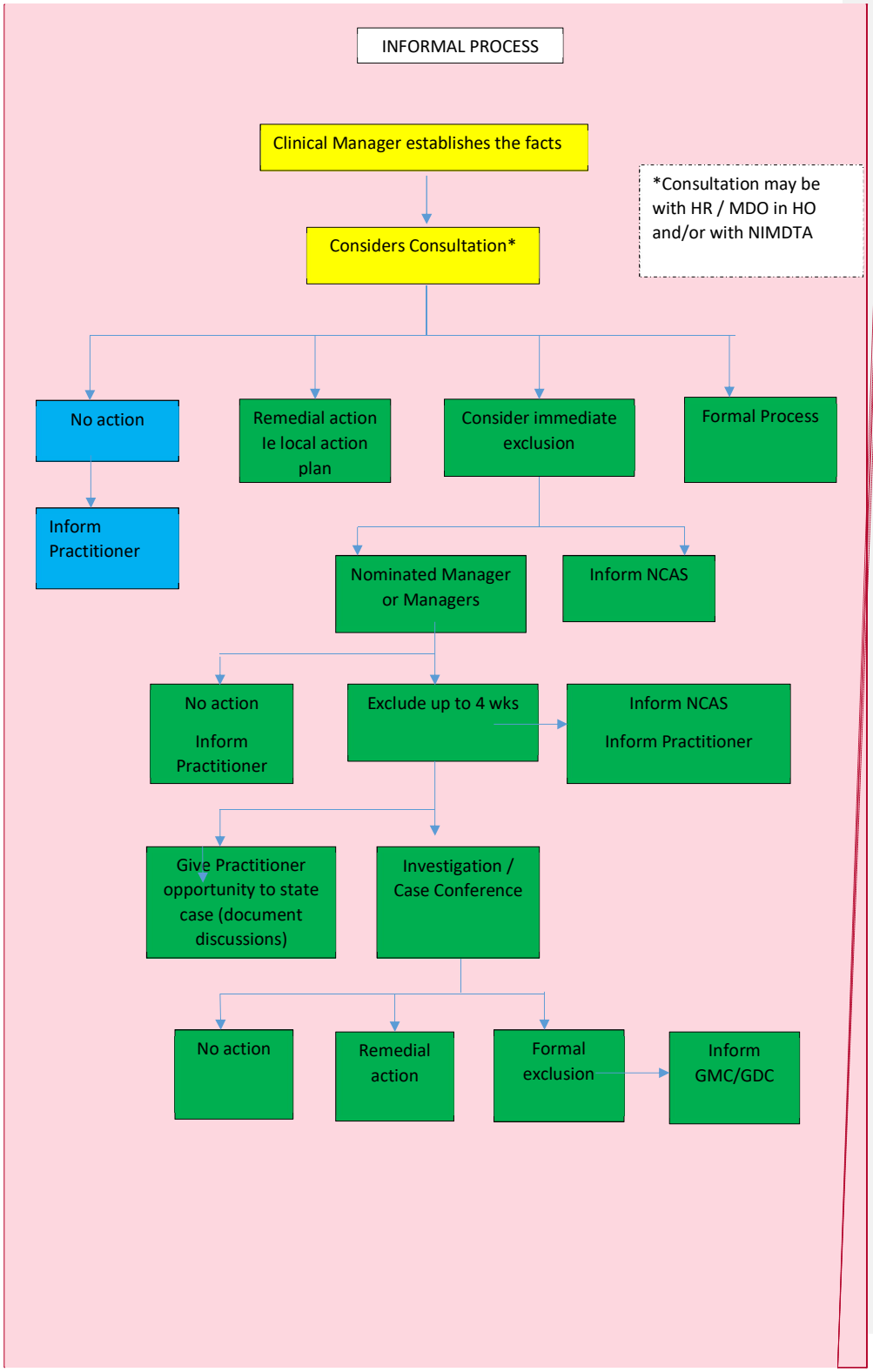
The Host Organisation will consider if and when it is necessary to consult with NIMDTA when an issue arises.

The following flowcharts outline the informal and formal stages of MHPS under the Single Employer model, and are colour coded to clarify the roles and responsibilities of NIMDTA and Host Organisations.

Key:

Host Organisation
NIMDTA
NIMDTA or Host Organisation depending on situation and decision maker

DRAFT

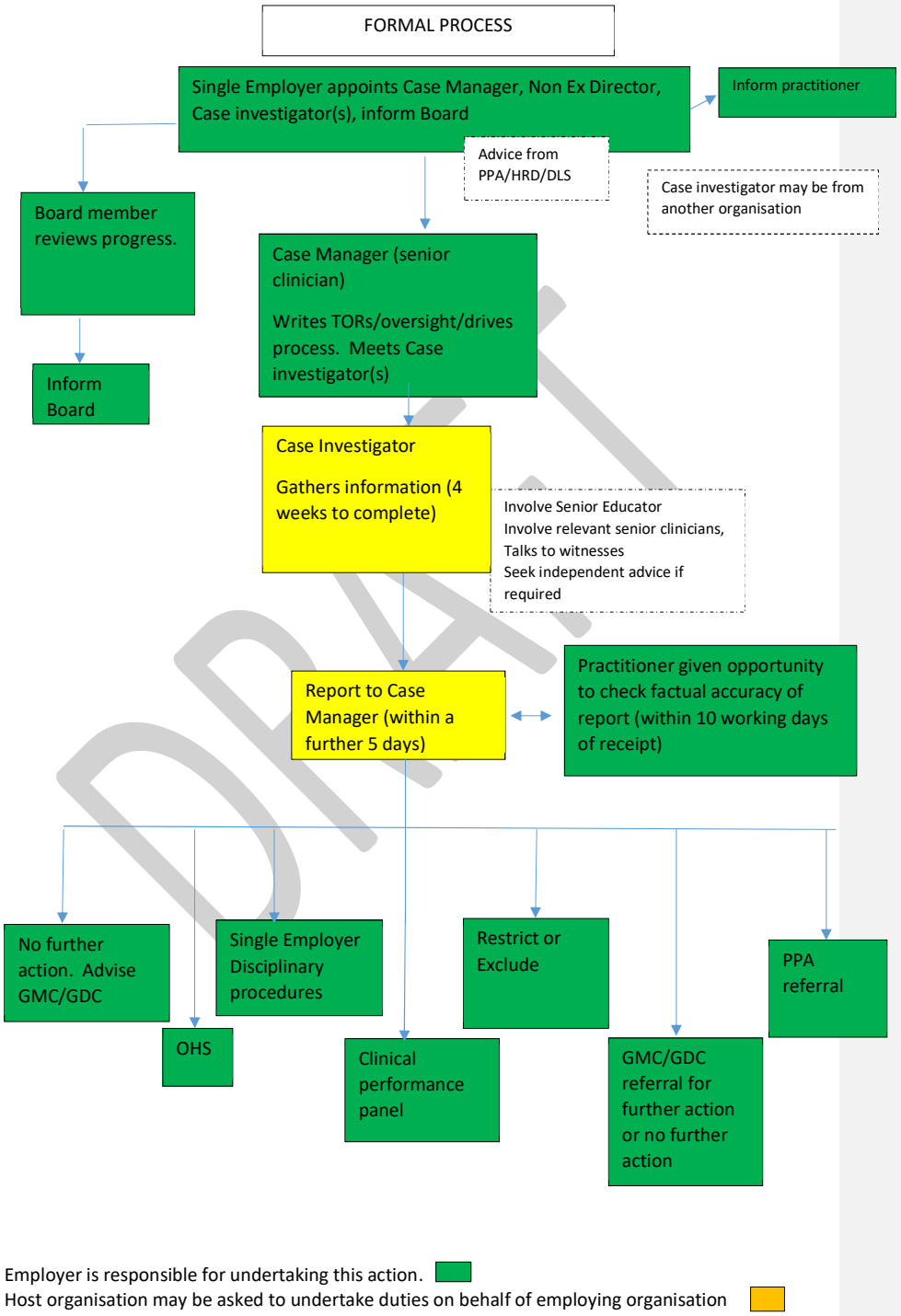


Commented [GH1]: Should 'consider immediate exclusion' box be moved up a line as it could be a precursor to formal process

Commented [GH2]: For NCAS read PPA

Commented [GH3R2]: Are additional resources going to be put in place to meet stated time lines given the current time frame required to complete such investigations

Commented [GH4R2]: As part of the ' clinical manager establishing the facts' (yellow box) the practitioner needs opportunity to state case



Employer is responsible for undertaking this action.
Host organisation may be asked to undertake duties on behalf of employing organisation

DRAFT

Roberts, Naomi

From: Lucinda Wright [redacted]
Sent: 30 July 2019 13:31
To: Hynes, Liz
Subject: Draft addendum to MHPS
Attachments: Draft addendum to MHPS - single employer model - DDiT 1.7.19 jc (003).docx

Dear Liz

Please find attached bma comments.

Best regards

Lucinda

Lucinda Wright
Senior employment adviser
BMA Northern Ireland

16 Cromac Place, Cromac Wood, Belfast, BT7 2JB
T: [redacted] | F: [redacted] | E: [redacted]

The BMA is a trade union representing and negotiating on behalf of all doctors and medical students in the UK.

A leading voice advocating for outstanding health care and a healthy population. An association providing members with excellent individual services and support throughout their lives.

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http://www.bma.org.uk

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

Roles and Responsibilities

[*Transitional Operational Guidance*]

DDiT SINGLE EMPLOYER MODEL

MAINTAINING HIGH PROFESSIONAL STANDARDS

This addendum has been drawn up in collaboration and in partnership with NIMDTA, HSC Trusts and the BMA, [redacted].

It does not change the way in which the MHPS framework works.

As employer, NIMDTA has overall responsibility for any Maintaining High Professional Standards process involving doctors and dentists in training, employed under the single lead employment model. NIMDTA should therefore be notified by the Host Organisation about all potential concerns about a doctor or dentist in training at the earliest opportunity.

Preliminary enquiries may be necessary and will usually be undertaken by the Host Organisation to establish whether there is a concern. Where preliminary enquiries have been undertaken, NIMDTA should be notified by the Host Organisation and provided with the outcome of these enquiries. This includes where it is determined that there is not an actual concern so that NIMDTA, as employer, is provided with the opportunity to confirm support for the Trust decision that no action is necessary.

In collaboration with the Host Organisation, NIMDTA will ensure that concerns about the conduct, performance and health of each trainee are handled in accordance with the Maintaining High Professional Standards Framework.

The attached flowcharts have been designed to help identify the roles and responsibilities of both the employing organisation (NIMDTA) and the Host Organisation.

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

ROLES AND RESPONSIBILITIES FOR MHPS

The following flowcharts outline the informal and formal approaches of MHPS under the Single Employer model, and are colour coded to clarify the roles and responsibilities of NIMDTA as the Single Employer and Host Organisations.

Key:

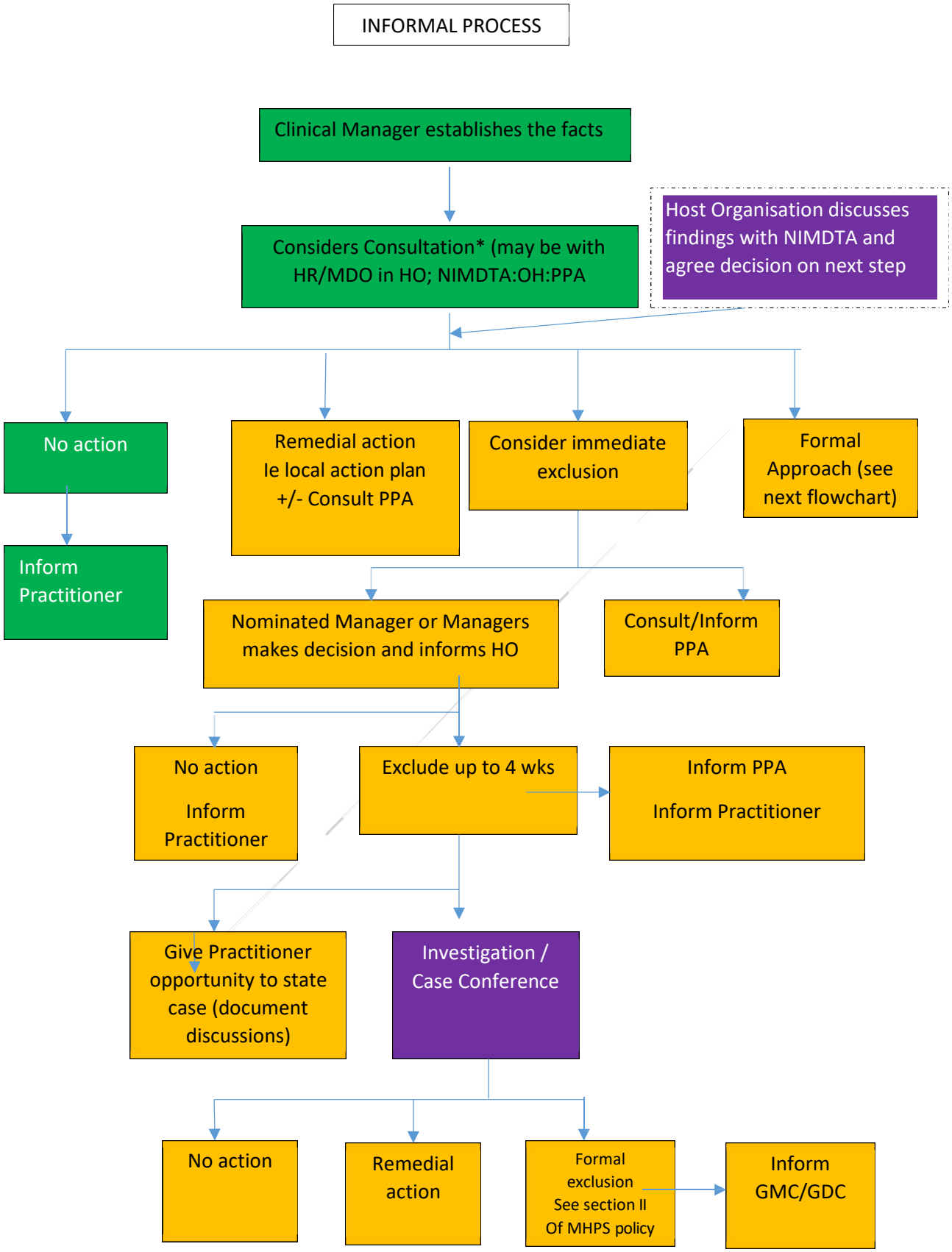
Host Organisation

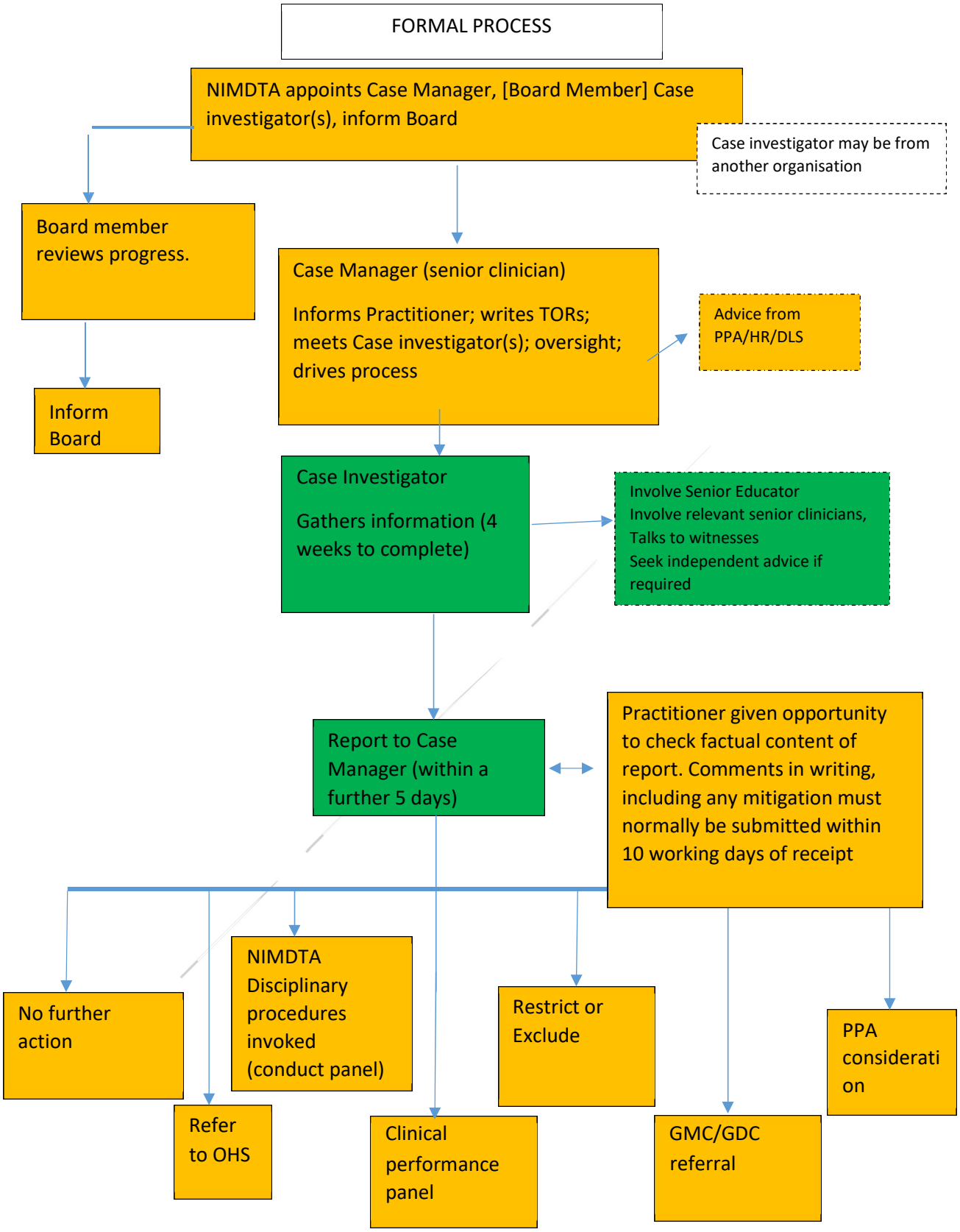
NIMDTA (Single Employer)

SE or Host Organisation depending on situation and decision maker may undertake this action

This document will be kept under review.

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


INFORMAL PROCESS
Clinical Manager establishes the facts
Considers Consultation* (may be with HR/MDO in HO; NIMDTA:OH:PPA
Host Organisation discusses findings with NIMDTA and agree decision on next step
No action
Inform Practitioner
Remedial action Ie local action plan +/- Consult PPA
Consider immediate exclusion
Formal Approach (see next flowchart)
Nominated Manager or Managers makes decision and informs HO
Consult/Inform PPA
No action
Inform Practitioner
Exclude up to 4 wks
Inform PPA
Inform Practitioner
Give Practitioner opportunity to state case (document discussions)
Investigation / Case Conference
No action
Remedial action
Formal exclusion See section II Of MHPS policy
Inform GMC/GDC



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

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[redacted]

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Irrelevant information redacted by the USI

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

Irrelevant information redacted by the USI

[redacted]

Roberts, Naomi

From: Hamilton, Karen
Sent: 16 July 2020 07:40
To: 'BHSCT - Peter McNaney'
Cc: Pengelly, Richard
Subject: RP5446 - Maintaining High Professional Standards (MHPS) Investigation - Dr Michael Watt
Attachments: RP5446 - Maintaining High Professional Standards (MHPS) Investigation - Dr Michael Watt.pdf

Mr McNaney,

Please see attached letter issued on behalf of Richard Pengelly.

Regards.
Karen

Karen Hamilton
On behalf of Richard Pengelly
Office of the Permanent Secretary
Department of Health (DoH)
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
Personal Information redacted by the USI

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

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Private and Confidential
Mr Peter McNaney CBE
Chairman
Belfast Health and Social Care Trust
Trust Headquarters
A-Floor, Belfast City Hospital
Lisburn Road
Belfast BT9 7AB
[redacted]

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: [redacted]
Fax: [redacted]

Email: [redacted]

Our ref: RP5446
SSUB-0179-2020

Date: 16 July 2020

Dear Peter

Maintaining High Professional Standards (MHPS) Investigation: Dr Michael Watt

I previously wrote to you on 3 October 2019 informing you that I had written to Martin Dillon regarding the highly important matter of the recall of neurology patients by the Belfast Trust and in particular Verita HR's draft report of its investigation into the conduct of Dr Watt.

The purpose of my letter of 3 October 2019 was to bring to your attention as Chairman of the Trust, to seek assurance that the Trust is taking every possible step to conclude the investigation into Dr Watt's conduct as quickly as possible and that any potential negligence and/or criminality uncovered by the investigation, which should be referred to the appropriate authorities for further investigation, has been properly addressed.

Martin Dillon has since retired from the Trust and as his successor as Chief Executive, Dr Cathy Jack, was Medical Director of the Trust at the time of the recall, it would not be appropriate for me to write to Cathy concerning the MPHS Investigation. I am therefore writing to you as Chair, given that you are not involved in the matters under investigation, and therefore the appropriate senior representative of the Trust given the position of the Chief Executive in relation to this matter.

The Department finds it frustrating that the Trust has not brought the MHPS Investigation to a clear conclusion by now. I appreciate that there have been some difficulties in progressing the Investigation due to the initial Case Manager for the investigation standing down in autumn 2019. The Department is aware that a replacement Case Manager was appointed but we have not received any further updates in recent months although again I appreciate that Trust staff involved in this matter have been diverted to take on pressing duties during the Covid-19 emergency period. However, now that the emergency has to some extent eased we would appreciate the Trust providing the Department, by 31 July 2020, with an update on the status of the investigation including a plan and timetable for bringing the investigation to a conclusion.

INVESTOR IN PEOPLE

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

The Independent Neurology Inquiry (INI) and the PSNI have separately requested the Department to disclose to them the Verita HR draft report for the purpose of informing their respective investigations into the circumstances of the recall. The PSNI has also asked the Department to disclose the report of the Royal College of Physicians of its review of the initial sample of Dr Watt's patient cases. The Department proposes to disclose these documents to the INI and PSNI by 31 July 2020 at the latest. In advance of this we will be informing Dr Watt's legal advisers of our proposed course of action. We will also notify Occupational Health and ask them to confirm that an appropriate safety management plan is in place for Dr Watt. The Department understands that both the Trust and Dr Watt have not completed a factual accuracy check of the Verita HR draft report. In disclosing the reports to the INI and PSNI we will therefore ensure that this is brought to their attention.

I look forward to hearing from you and would be available to meet if you would find a discussion of this matter useful.

Yours sincerely

RICHARD PENGELLY

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

FROM THE MINISTER OF HEALTH

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Mr Colm Gildernew MLA
Chair, Committee for Health
Room 410
Parliament Buildings
Stormont
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: [redacted]
Email: [redacted]

Your ref: C307/21
Our Ref: CORR/3871/2021
Date: 13th January 2022

Dear Colm,

Thank you for your letter dated 16 November 2021 asking that my Department provide the Health Committee with a copy of the draft report by Verita Consulting, in relation to a Maintaining High Professional Standards (MHPS) investigation regarding Dr Michael Watt.

The Verita report was commissioned by the Belfast Trust (the Trust) as part of an employment process under the MHPS framework, which expressly requires that confidentiality is maintained in respect of such processes. The draft Verita report also contains sensitive data including patient information. Therefore, such reports cannot be disclosed by the Trust, other than in appropriate legal proceedings and consequently the report is unable to be provided to the Health Committee as requested.

The Health Committee may wish to note that the Trust has confirmed that the draft Verita report was provided to the Independent Neurology Inquiry following a statutory notice requiring its production.

I hope you find this response helpful.

Yours sincerely

[redacted]

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

Roberts, Naomi

From: Claire Forsythe [redacted]
Sent: 17 January 2022 16:21
To: Moore, Martina
Cc: Cassidy, Gearoid; McKeown, Gareth; Murray, Kathryn; Margaret O'Brien (Dr); Michael Donaldson; Marlene Drummond; McMahon, Louise (HSCNI)
Subject: Maintaining High Professional Standards (MHPS)

"This email is covered by the disclaimer found at the end of the message."

Martina,

[redacted].

It is assumed that this will be included within the contracts of employment of the Dental Advisers and Medical Advisers employed by HSCB, as well as the two GPs who are employed by HSCB outside of DoIC. Whilst it may not expressly refer to or specifically stipulate MHPS, it is assumed that it is incorporated by reason of the DoH formal direction. Given the legal significance of this issue and that it is contractually binding, there needs to be an agreed policy in place to be operational from 1st April 2022 onwards. A revised policy would need to be agreed and issued by the DoH, possibly by way of issuing a new formal direction, setting out the mechanism to replace the specific role of the Board and the designated NE Director in oversight of all of this.

Engagement with BSO would be required to determine if they would be in a position to undertake this role and requirement from within their own structures.

Regards,

Louise
(Claire Forsythe sent on behalf of Louise McMahon)

From: Moore, Martina [redacted]
Sent: 11 January 2022 16:37
To: Louise McMahon; Cassidy, Gearoid
Cc: McKeown, Gareth; Murray, Kathryn
Subject: Maintaining High Professional Standards

Louise/Gearoid

We just had a meeting with BSO HR who are looking at areas where there would normally be NED involvement eg Remuneration Committee and what arrangements need to be put in place for April.
One area they referred to is with regards to MHPS and role NEDS currently play. From our understanding, in this context, MHPS relates to the medical advisers of the Board and BSO are advising consideration needs to be given the a mechanism to be in place for SPPG post April as there will no longer be a Board. There was also the suggestion that the standards need updating to reflect the new situation and given the time involved in this an interim solution

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may be required, and one example cited with the PHA.
To be honest we have not heard of this area before so I was wondering if this was something you had considered within your workstream and if not could you get someone to take a look at it and advise what is required. I looked up the standards there and from my reading I was wondering if BSO could not fulfil this requirement through they own structures?

Separately I know you are looking at creating a pool of NEDs for the IC Committees and I was wondering if you could provide an update on where you are with this as one option for a remuneration committee they wish to explore is use of the pool (if possible).

Grateful for your consideration and advice

Martina

Martina Moore
Director of Organisational Change
Transformation, Planning & Performance Group
Department of Health
Annex 3 Castle Buildings
BT4 3SL
PHONE: Personal Information redacted by the USI | EXT: Personal Information redacted by the
MOBILE: Personal Information redacted by the USI

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Roberts, Naomi

From: McMahon, Louise (HSCNI)
Sent: 25 January 2022 23:41
To: Moore, Martina
Cc: Cassidy, Gearoid; McKeown, Gareth
Subject: RE: Maintaining High Professional Standards (MHPS)

"This email is covered by the disclaimer found at the end of the message."

Martina,

This refers to practitioners working in the contracted services whereas Managing High Professional Standards applies to doctors and dentists employed by the HSCB so in answer to the main part of your question – this document does not relate to MHPS. It does however usefully put into context the issues of the Committees on which, as you know, we are very active.

Louise.

From: Moore, Martina [redacted]
Sent: 25 January 2022 15:59
To: Louise McMahon
Cc: Cassidy, Gearoid; McKeown, Gareth
Subject: FW: Maintaining High Professional Standards (MHPS)

Louise

Thank you for the response below – I am meeting Naresh tomorrow to discuss further.

As part of our research into this area, we have located the attached document in the Departmental files relating to MHPS and I was wondering if you could clarify if the process within the attached is in addition to that laid out in the MHPS framework or is to how the HSCB implemented it? Perhaps they are totally unrelated and if so apologies just trying to understand the issue here.

Grateful for your advice.

Martina

From: Claire Forsythe [redacted]
Sent: 17 January 2022 16:21
To: Moore, Martina [redacted]
Cc: Cassidy, Gearoid [redacted]; McKeown, Gareth [redacted]; Murray, Kathryn [redacted] Margaret O'Brien (Dr) [redacted] Michael Donaldson [redacted]; Marlene Drummond [redacted]; Louise McMahon [redacted]
Subject: Maintaining High Professional Standards (MHPS)

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

Martina,

[redacted]

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Regards,

Louise
(Claire Forsythe sent on behalf of Louise McMahon)

From: Moore, Martina [redacted] Personal Information redacted by the USI
Sent: 11 January 2022 16:37
To: Louise McMahon; Cassidy, Gearoid
Cc: McKeown, Gareth; Murray, Kathryn
Subject: Maintaining High Professional Standards

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Grateful for your consideration and advice

Martina

Martina Moore
Director of Organisational Change
Transformation, Planning & Performance Group
Department of Health

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

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BT4 3SL
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Roberts, Naomi

From: McCaig, Tracey (HSCNI)
Sent: 26 May 2022 10:34
To: McMahon, Louise (HSCNI); McKeown, Gareth; Anderson, Gerry; Paula Smyth; Mark Bradley; McWilliams, Lisa (HSCNI); Whittle, Brendan (HSCNI); Cavanagh, Paul (HSCNI); McIlwrath, Pamela; Catherine McKeown; Stephen Wilson (PHA)
Cc: Moore, Martina; Fyffe, Sarah
Subject: RE: SPPG NEDs option paper - for comment by 27th May
Attachments: NEDs Options Paper v0.4.DOCX

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Feels like the MHPS element may need separate consideration to the core Directors element??

From: Louise McMahon
Sent: 26 May 2022 09:54
To: Tracey McCaig; 'McKeown, Gareth'; Gerry Anderson; Paula Smyth; Mark Bradley; Lisa McWilliams; Brendan Whittle; Paul Cavanagh; McIlwrath, Pamela; Catherine McKeown; Stephen Wilson (PHA)
Cc: Moore, Martina; Fyffe, Sarah
Subject: RE: SPPG NEDs option paper - for comment by 27th May

Tracey, Gareth,

Ref. Maintaining High Professional Standards – this relates to doctors and dentists employed by the SPPG – there different arrangements for contractors which are not within the scope of this paper.

Louise.

From: Tracey McCaig
Sent: 26 May 2022 07:47
To: Louise McMahon; 'McKeown, Gareth'; Gerry Anderson; Paula Smyth; Mark Bradley; Lisa McWilliams; Brendan Whittle; Paul Cavanagh; McIlwrath, Pamela; Catherine McKeown; Stephen Wilson (PHA)
Cc: Moore, Martina; Fyffe, Sarah
Subject: RE: SPPG NEDs option paper - for comment by 27th May

Hi Gareth – I started typing alongside Louise's comments and then stopped.

In general I am not sure that we have been clear about the employment status or responsibility/accountability for the Directors – ie Dep Sec is the person we are accountable to for our performance and in any option we would need to find a way to report to an independent remuneration committee.

I have relooked at the remuneration committee requirements set out in the paper:

- Remuneration committee, in particular, implementing senior executive pay circulars in respect of SPPG staff who will retain their HSC senior executive terms and conditions. NEDs and an ALB Chairman would typically comprise a Remuneration Committee and would for example, consider performance appraisals in agreeing Director salaries;

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This is something that we need to find an option for and for any option we will develop will require a wraparound process – no group of NEDs will be able to replace the HSCB NEDs in this way – I think we need to be clear before we go into the options ie all will be a problem in this way, but which gives the best outcome with the wraparound process/legal view for employees etc.

- Matters relating to senior staff under both the Disciplinary and Grievance procedures. This may involve NEDs hearing representations, making disciplinary or grievance decisions and hearing appeals;

  Query – by senior staff are we referring only to the Directors? If yes can we make this clear that this is for 5 staff, it sets the options in context

- Complaints made with regards to Conflict, Bullying or Harassment (CBH) against senior staff. While not specifically written into the CBH policy, there are rare occasions when a NED may hear representations and may be required to make decisions regarding a CBH case or hear appeals; and

  Query – by senior staff are we referring only to the Directors? If yes can we make this clear that this is for 5 staff, it sets the options in context

- Maintaining High Professional Standards – this Framework sets out the specific roles of the Board of each relevant organisation and that of a "designated Board member" i.e. NED, who may oversee the case and consider any representations from the practitioner regarding their potential exclusion.

  Query – is this covered by the panel being set up by FHS team?If yes we need to say this is covered and only the 3 points above. If not it feels this needs a separate solution

I think then we need to explore option 1 and option 2 being DOH and BSO in the first instance to rule in or out. I think the text needs to be standardised/ranked/scored in the boxes as we are not consistent in each. I would suggest something like

- Direct link to delivery of role/function - eg yes DOH and no BSO
- Employer – eg DOH no BSO yes
- Legal - ….

  Etc

  This will then show problems with both these options.

At this stage then we can bring in others – I think we have too many and I question adding in PHA and others, perhaps simplify by the current panel for FHS or another separate independent. These could be scored as with the others.

All of this will get us to a position of no easy fit, therefore we need to construct something to fit – from the best of the above and then work out the negatives which we need to wrap a process round and share with Tus for the Directors performance issues.

I think we need to set a little time aside with a few of us to work it through – a bit like we did last year for the wider piece. I am sure we can find a solution.

Tracey

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

From: Louise McMahon
Sent: 26 May 2022 03:21
To: 'McKeown, Gareth'; Gerry Anderson; Paula Smyth; Mark Bradley; Tracey McCaig; Lisa McWilliams; Brendan Whittle; Paul Cavanagh; McIlwrath, Pamela; Catherine McKeown; Stephen Wilson (PHA)
Cc: Moore, Martina; Fyffe, Sarah
Subject: RE: SPPG NEDs option paper - for comment by 27th May

Gareth,

Comments attached.

Louise.

From: McKeown, Gareth Personal Information redacted by the USI
Sent: 19 May 2022 13:17
To: Gerry Anderson; Paula Smyth; Mark Bradley; Tracey McCaig; Lisa McWilliams; Brendan Whittle; Paul Cavanagh; McIlwrath, Pamela; Catherine McKeown; Louise McMahon; Stephen Wilson (PHA)
Cc: Moore, Martina; Fyffe, Sarah
Subject: SPPG NEDs option paper - for comment by 27th May

Colleagues,

Please find enclosed draft options paper seeking to identify the best solution for NED roles in SPPG. This is an outline paper, identifying 6 options, none of which have been discounted.
Options analysis and conclusion as well as Sections 6 and 7 are intentionally blank at this stage.

I am requesting comments from you in relation to the options identified in order to develop the further paper, so that a recommended option can be identified.

I would then propose re-issuing a revised paper reflecting comments received and to organise a workshop to in early/mid June to discuss. I would hope to table this paper with Oversight before the end of June, seeking endorsement of recommended option.

I have attached a review template, if I could ask you all to populate this with your comments rather than annotate the document. A consolidated template with all comments received will issue with the updated paper. If I could ask for comments from you by **Fri 27th May.**

Thank you
Gareth

Gareth McKeown
HSCB Migration Project Manager
Directorate of Organisational Change
Department of Health
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

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infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

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13.45 Accountability for patient safety is ultimately the responsibility of the Trust Board, who will, for the most part, seek assurance from the Medical Director. While it may be perfectly reasonable for the Medical Director to have oversight of doctors as regards patient safety, there are impediments, which can cumulatively threaten to undermine a Medical Director, and make their task more difficult. This included:

(i) The inability to access in a compendious and clear manner, information on clinical complaints The present Datix system receives a vast array of data which is insufficiently distinguished by those inputting into the system, and the volume of information is such that absent proper analysis, it is difficult to discern a pattern of concern except in the most general sense

(ii) The restricted flow of information between service departments and the Medical Director's Office. An inadequate appreciation of the management role by Clinical Directors encourages a culture, where issues of possible clinical concern are not escalated and the high threshold adopted by clinicians before registering a concern to the Medical Director ensures that a good deal of information is retained within the relevant department and, in this case, neurosciences.

(iii) The intricacies of the Maintaining High Professional High Standards ("MHPS") procedures make dealing with doctors in difficulty a more cumbersome process than should be the case Good management can and should filter out issues which need not be formalised. Nevertheless, an informal process such as the one which operates within MHPS, must be robust and well documented The present informal process within MHPS is opaque and often leads to different doctors taking widely different approaches to investigation. Informal processes are sensible and the managerial norm, but they must be coherent. It is recognised that a critique of the MHPS procedure is, of itself, a significant and discrete piece of work, which is beyond the scope of this Inquiry. The Inquiry Panel does wish, however, to place on record its view that reform of the existing procedure is long overdue The present balance of the procedure is weighted towards the protection of the doctor and in the confidentiality of the process rather than patient safety

13.46 The Inquiry Panel again emphasises that it is not its role to comment on the merits of various models of NHS governance The reality is that a managerial system is in place and is unlikely to change in the foreseeable future. Recommendations within this report are, therefore, framed on that basis. The challenge, however, is to recognise the influence of medical culture within the Belfast Trust and attempt to address how the professional model can be positively reconciled with a management model to the

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(14) The NI Department of Health should review and evaluate the progress made by the Belfast Trust in developing new information gathering and governance processes[1]

(15) The NI Department of Health should emphasise to healthcare organisations the potential dangers of lone working and to develop guidance on the many ways in which it can be avoided

(16) The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations

(17) The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients

(18) The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentially. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors

(19) The NI Department of Health should initiate a detailed review in relation to the role of clinical directors and clinical leads to address issues arising from this report and their training needs

(20) The NI Department of Health should ensure that Trust Boards have a Safety and Quality Sub-Committee, which has a similar status to the Audit Committee

(21) The NI Department of Health should clarify with the Trust Boards the nature of their accountability for patient safety

(22) The NI Department of Health should issue guidance to healthcare organisations about the information to be given to patients when a clinician's practice is restricted in any way

(23) The NI Department of Health should review (and if necessary, change) the early warning alert process and the serious adverse incident process to assure itself that these processes are clear, well understood and operate in the interests of patients

(24) The NI Department of Health should remind commissioners of healthcare that they have a responsibility to commission safe care and, therefore, to be assured of the safety provided by any Independent Healthcare Provider

[1] To assist with investigating complaints, the Belfast Trust has implemented a clinical record review To protect against the risk of lone working, additional peer review is being incorporated in the Trust through an initiative known as 'Building Effective Teams'. To enable the Medical Director at the Trust to be able to access accurate and useful information on a clinician's practice, a live professional governance reporting system has been put in place

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Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phioblí

Subject:

Reporting and follow-up on serious adverse incidents and Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Department

Circular Reference: HSC (SQSD) 19/2007

Date of Issue: **30 March 2007**

For action by:

- Chief Executives of HSC Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive designate, HSC Authority
- Chief Officers, HSC Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and HSC Trusts
- Directors of Dentistry in HSS Boards
- Directors of Pharmacy in HSS Boards
- Directors of Nursing in HSC Boards and HSC Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSC Trusts
- Regional Director, Commissioning
- Area Directors, Commissioning
- Chairs, Local Commissioning Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to notify a number of changes to the reporting and management of Serious Adverse Incidents (SAIs) and to introduce the reporting on breaches of patients waiting in excess of 12 hours

Enquiries:

Any enquiries about the content of this Circular should be addressed to:

Safety & Quality Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: 028 9052 2239
Personal Information redacted by the USI

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005
HSS (PPM) 02/2006
DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
Priorities for Action 2007-08

Superseded documents

Annex to Circular HSS (PPM) 02/06

Status of Contents:

Action

Implementation:

From 01 April 2007

(To be reviewed by 31 March 2008)

Additional copies:
Available to download from
Personal Information redacted by the USI

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

Safety, Quality & Standards Directorate

For action:

Chief Executives of HSC Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

For information:

Chief Executive designate, HSC Authority
Chief Officers, HSC Councils
Directors of Public Health in HSS Boards
Directors of Social Services in HSS Boards and HSC Trusts
Directors of Dentistry in HSS Boards and HSC Trusts
Directors of Pharmacy in HSS Boards and HSC Trusts
Directors of Nursing in HSC Boards and HSC Trusts
Directors of Primary Care in HSS Boards
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Chairs, Local Commissioning Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission
CSCG/Risk management leads
Unscheduled care improvement managers

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Email:
maura.briscoe Personal Information redacted by USI
dean.sullivan Personal information redacted by USI

Circular HSC (SQS) 19/2007

30 March 2007

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS; AND

REPORTING ON BREACHES OF PATIENTS WAITING IN EXCESS OF 12 HOURS IN EMERGENCY CARE DEPARTMENT

Introduction

The purpose of this circular is to:

a) advise you of refinements to the Department's Serious Adverse Incidents (SAI) system and of changes which will be put in place, from April 2007, to promote learning from

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

SAIs and reduce unnecessary duplication of paperwork for Trusts, Boards and Agencies, **Section 1;** and

b) clarify arrangements for the reporting on breaches of patients waiting in excess of 12 hours in emergency care departments, **Section 2.**

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely

MAURA BRISCOE
Director Safety, Quality and Standards Directorate

DEAN SULLIVAN
Director of Service Delivery

SECTION 1: Refinements to Serious Adverse Incident (SAI) System

1. This section outlines refinements to the Department's SAI system by:

   a) promoting increased reporting of SAIs;
   b) clarification of how SAIs, relating to family practitioner services, should be reported;
   c) amendments to existing reporting form (Annex A);
   d) learning from SAIs through development of a new proforma (Annex B); and
   e) integration of follow-up action on SAIs.

Promoting increased Reporting of SAIs

2. Since the introduction, in July 2004, of interim reporting procedures for SAIs and near misses for HSS Boards, HSC Trusts, Agencies and Family Practitioner Services, the Department has been monitoring the effectiveness of the system. HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager, within a HPSS organisation/Agency, when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

   (i) be serious enough to warrant regional action to improve safety or care;
   (ii) be of public concern (such as serious media interest); or
   (iii) require an independent review.

3. To date, the majority of SAIs reported to the Department arise from the community sector with relatively small numbers being reported from the acute sector or the family practitioner services. This circular re-emphasises the need to report SAIs, which meet the above criteria. This needs to be promoted in order to develop a more complete picture of the breadth of SAIs and their associated learning.

Reporting of SAIs from the Family Practitioner Services

4. In the interests of learning, the Department welcomes the increasing number of family practitioners who are reporting adverse incidents to their HSS Board. When a HSS Board receives an adverse incident, which falls within the above criteria, it is the HSS Board's responsibility to complete the SAI proforma (Annex A) and refer it to the Department. The HSS Board may seek to clarify the nature of the adverse incident in order to assess whether it meets the above criteria and whether there is any local or regional learning.

Amendments to existing reporting proforma (Annex A)

5. In order to ensure appropriate information is returned to the Department, and to avoid unnecessary follow-up communication, the SAI Report proforma (formerly attached as the Annex to Circular HSS (PPM) 02/06) has been revised as follows.

6. Trusts should continue to ensure that all SAIs are reported to their commissioning HSS Board as a matter of course. This is even more important given the role the HSS Boards will be undertaking regarding follow-up action in the implementation of their individual SAI handling procedures.

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Box 2
Service pressure incidents

7. When reporting incidents relating to pressures in the Child & Adolescent Mental Health Services, Box 2 should contain details of the action taken by the reporting organisation to minimise risks in accordance with the Department's letter of 13 March 2006 on *Under 18 Year Olds in Adult Mental Health Facilities* (http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd_guidance_dhssps_guidance.htm). Reporting organisations should also be aware that where under 18 year olds are placed in adult learning disability facilities, these should also be reported to the Department.

Box 4
Classification of incidents

8. Officers are reminded to complete the classification assessment. (Circular HSS(MD) 12/2006 *How to Classify Incidents and Risks* refers)

Box 7
Actions on employment-related issues arising from incidents

9. This new Box has been added to include any initial action taken by the reporting organisation on employment-related issues as a result of the SAI (where this is known within 72 hours). This would include suspension; referral under the Protection of Children and Vulnerable Adults (POCVA) procedures; or referral to a regulatory body, the National Clinical Assessment Service (NCAS) or Police Service (PSNI).

10. Specifically in relation to POCVA procedures, child care organisations must refer an individual who is or has been employed in a regulated position to the Disqualification from Working with Children (NI) List where there have been allegations that the individual has on the grounds of misconduct harmed or placed a child at risk of harm and the individual has resigned or been suspended or transferred to a non-regulated position. Non-child care organisations may also refer in such circumstances (Article 4(1) of POCVA refers). The Department strongly recommends that referrals in the latter circumstances, while not compulsory, are good practice and will assist organisations in making informed decisions about individuals under investigation, who may seek work in a regulated position in either voluntary or paid employment.

11. Providers of care to vulnerable adults in residential homes, nursing homes or in a vulnerable adult's own home must also refer care workers to the Disqualification from Working with Vulnerable Adults (NI) List, if a care worker on the grounds of misconduct has harmed or placed at risk of harm, a vulnerable adult (Article 36 of POCVA refers).

12. Referrals under the POCVA procedures must be forwarded without delay in all cases where the criteria for a referral are met, including cases where internal investigations are ongoing and the organisation has not yet decided to dismiss the individual or confirm the transfer to a non-regulated or caring position.

Learning from SAIs through the development of a new proforma (Annex B)

13. From April 2007, a new proforma will be introduced to enable learning arising from adverse incidents to be captured and shared. When the Department's SAI group seeks the learning from a particular incident, the follow-up proforma at Annex B will be issued to the reporting organisation usually within 12 weeks of the date of the incident (or receipt of the SAI report where the date is not known). It is hoped that the information gathered from this source will be easier to analyse and disseminate effectively and faster at local level and that it will reduce the need for the Department to request copies of Investigation Reports or Root Cause Analysis. The learning proforma should also be copied to the relevant area Board; however, Boards will continue to operate their individual SAI handling procedures and may request further information as part of their follow-up action. The 12 weeks deadline has been selected in order to align with the reporting requirements of other organisations such as the Mental Health Commission.

Integration of follow up action

14. The Department's SAI group is currently piloting participation of each of the four HSS Boards in the Department's SAI process. It has been decided to extend membership in order to:

- minimise duplication between the Department's and Boards' handling procedures;
- promote fast and effective dissemination of learning across the HPSS; and
- achieve consistency of approach.

The membership of the Department's SAI group will continue to be reviewed throughout 2007/08.

Conclusion

15. The SAI system is designed to inform the Department of serious adverse incidents which meet the three criteria outlined in paragraph 2. This remains an interim procedure pending clarification of the future direction of the National Patient Safety Agency and local changes arising from the Review of Public Administration.

16. Summary learning arising from SAIs received between July 2004 and December 2005 was documented in the Department's publication *Supporting Safer Services (June 2006).* A further report, of the learning arising from reported SAIs between January 2006 and March 2007 will be issued later this year.

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

ANNEX A

SERIOUS ADVERSE INCIDENT REPORT

1. Organisation:

Incident Identifier No.

2. Date and brief summary of incident:

3. Why incident considered serious:	**Briefly, explain why this SAI meets the criteria:**
a. warrants regional action to improve safety or care within the broader HPSS; b. is of public concern; or c. requires an independent review.	

4. Immediate action taken:

Classification of incident as initially assessed by organisation: Catastrophic / Major / Moderate / Minor / Insignificant

5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted):

Are there any aspects of this incident which could contribute to learning on a regional basis?

6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):

7. Has any employment-related action been taken as a result of this incident, such as:
a. suspension from duties? Y/N
b. a referral been made to POCVA? Y/N
c. a referral to the relevant Professional Regulatory Body, NCAS or PSNI? Y/N (if 'Yes', specify which organisation)

8. Other Organisations informed:		**Date informed**	Other (please specify) Y/N
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		**Date informed:**
RQIA	Y/N		

9. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*)
Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

ANNEX B

LEARNING FROM SERIOUS ADVERSE INCIDENT

The Department will complete Parts 1, 2, 3a) and 4 from original reporting template before issuing to reporting organisation

1. Organisation:

Incident Identifier No.

2. Date and brief summary of incident: (As provided in reporting template)

3. a) Classification of incident as initially assessed by organisation:

3. b) Has Classification changed since initial assessment? Catastrophic / Major / Moderate / Minor / Insignificant

4. Regional action recommended in reporting template

5. (Where applicable) Date of organisation's internal review: __/__/__

(Where applicable) Date independent review concluded: __/__/__

6. A summary of the key learning points emerging from local investigation of SAI: *

For reporting organisation:

(i)
(ii)
(iii)

For region:

(i)
(ii)
(iii)

(additional page(s) can be used if necessary)

7. Since the initial report, has any further employment-related action been taken as a result of this incident, such as:

a. suspension from duties? Y/N
b. a referral been made to POCVA? Y/N
c. a referral to the relevant Professional Regulatory Body, NCAS or PSNI? Y/N (if 'Yes', specify which organisation)

8. *Should any further points of learning emerge from other external sources: (eg. Coroner's inquest report, RQIA report/improvement review, MHC visit, HSE(NI) investigation, PSNI investigation, etc), the reporting organisation may submit this additional information at a later date

(i)
(ii)
(iii)

9. I confirm that the designated senior manager and/or Chief Executive are aware of the follow-up action taken and that the learning has been disseminated and implemented throughout the organisation as a result of this SAI. (*delete as appropriate*)

Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

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

SECTION 2: Breaches of Patients waiting in excess of 12 hours in Emergency Care Departments

1. Section 2 is designed:

   a) to clarify arrangements for the reporting and learning from breaches of the 12 hour Accident & Emergency (A&E) standard; and

   b) to introduce a new reporting form (Annex 1) for breaches of this standard; such reports should be sent to the Department to ensure that appropriate follow-up action occurs and that any learning arising from these breaches is captured centrally.

Emergency Care Reform Targets

2. On 13 November 2006, the Department's Service Delivery Directorate issued a Definitions and Guidance Framework for Emergency Care Reform (Letter DS 154-06 and related guidance refers). The Framework advised the HPSS that from 1 April 2007 the SAI reporting system would be used to alert the Department of breaches of the 12 hour A&E standard. The Department believes that a single reporting portal on these issues is a practical approach during the current RPA changes.

3. When a report is submitted to the Department, these reports will **not** be handled in the same way within the Department as other SAIs. They will not be considered by the Department's SAI Review Group (unless, of course, the excess waiting has resulted in a serious adverse incident which has caused harm to patients or staff as defined in Section 1, paragraph 2). Instead they will be referred onwards to the Service Delivery Directorate for appropriate follow-up action and cascade of learning. Breaches of the 12 hour A&E standard should be reported separately using the proforma at Annex 1.

Completing the new reporting proforma (Annex 1) for breaches in 12 hour waiting times

4. Annex 1 contains the new reporting form for documentation of breaches of the 12 hour standard and reporting such breaches to the Department.

Box 2

5. When reporting a breach, Box 2 should contain the following details:

   (i) Where a breach of the 12 hour standard has occurred, but the patient has now been placed in a ward:

   - indicate the total length of time the patient was in A&E (from time of arrival to time of departure);
   - confirm whether the patient was placed in a ward clinically appropriate for their condition;
   - if not, indicate what type of ward the patient was placed in; and
   - confirm whether the Trust policy for managing escalating pressures was implemented (Section 5 of the Definition and Guidance Framework); or

(ii) Where a breach of the 12 hour standard has occurred and the patient has not yet been placed in a ward:

- describe the current situation.

Box 9

6. All breaches of the 12 hour standard should be reported to the designated senior manager within the Trust to ensure that there is corporate knowledge of the breach.

Conclusion

7. The Department has adopted a pragmatic approach to the reporting of breaches of the 12 hour standard to the Department using the same reporting portal as SAIs. Learning arising from these breaches will be collated centrally by the Service Delivery Unit (SDU) and will be fed back to Trusts through routine SDU monitoring meetings.

8. Such arrangements will be reviewed in 2008, in light of changes arising from the Review of Public Administration and may be subject to change.

ANNEX 1

REPORT ON BREACH OF PATIENT WAITING IN EXCESS OF 12 HOURS

1. Organisation:

Incident Identifier/A&E No.

2. Date and brief summary of incident:

(i) Where a breach of the 12 hour standard has occurred, but the patient has now been placed in a ward:

- indicate the total length of time the patient was in A&E: _____ hours
- was patient placed in a ward clinically appropriate for their condition? (Y/N)
- if 'No', indicate what type of ward the patient was placed in: _____
- was Trust policy for managing escalating pressures implemented? (Y/N)

(ii) Where a breach of the 12 hour standard has occurred and the patient has not yet been placed in a ward:

- describe the current situation

9. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this breach and is/are content that it should be reported to the Department. (*delete as appropriate*)
Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:
adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 3206

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Noel McCann
Director of
Planning & Performance Management

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Date: 7 July 2004

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

For information:

Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups

Circular HSS (PPM) 06/04

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

Introduction

1. The purpose of this guidance is to provide interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses, pending the issue of more comprehensive guidance on safety. This will be issued once the work currently being undertaken by the Department on the strategic review of the reporting, recording and investigation of adverse incidents and near misses has been concluded.

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

2. This interim guidance highlights, in particular, the need for the Department to be informed immediately about incidents which are regarded as serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff. It also draws attention to the need for the Department to be informed where a Trust, Board or Special Agency considers that an event is of such seriousness that it is likely to be of public concern. In addition, the guidance requires Trusts, Boards or Special Agencies to inform the Department where they consider that an incident requires independent review.

3. The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating, for example, to medical devices and equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the Department. **These systems should continue to be used in addition to the action required by this interim guidance**. In the context of contractual arrangements for the independent family practitioner services, practices should report serious incidents, in the first instance, to the relevant HSS Board, which will communicate with the Department as appropriate.

Background

4. The consultation paper *Best Practice Best Care*, published by the Department in April 2001, recognised the need for more effective arrangements for monitoring adverse incidents. As a result, a Safety in Health and Social Care Steering Group was established by the Department, with a remit to develop a strategic approach to the reporting, recording and investigation of adverse incidents and near misses and the promotion of good practice to minimise risk.

5. As part of its work, the Steering Group is also undertaking an evaluation of the effectiveness of systems used to identify and manage adverse incidents and near misses, including the Northern Ireland Adverse Incident Centre (NIAIC). NIAIC operates a voluntary system for reporting and investigating adverse incidents in the HPSS and issues alerts and other material on the safety of devices and equipment.

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6. It is hoped that the Steering Group will conclude its work later this year, following which comprehensive guidance on safety and the promotion of learning will be brought forward. This may include links, where appropriate, with the National Patient Safety Agency in the NHS.

Defining Serious Adverse Incidents

7. Preliminary feedback from the Steering Group's work highlights a lack of uniformity in incident reporting and management in the HPSS. This also applies to the definition of what constitutes a serious adverse incident.

8. In line with the action required by this Circular, the Department considers that a serious adverse incident should be defined as "*any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led, or could have led, to serious unintended or unexpected harm, loss or damage*". This may be because:

- it involves a large number of patients;
- there is a question of poor clinical or management judgement;
- a service or piece of equipment has failed;
- a patient has died under unusual circumstances; or
- there is the possibility or perception that any of these might have occurred.

9. Examples of serious adverse incidents include:

- any incident involving serious harm or potentially serious harm to a patient, service user or the public. This could include disease outbreaks, apparent clinical errors or lapses in care;
- any incident which has serious implications for patient or staff safety – involving potential or actual risk to patients or staff;
- any incident involving serious compromises or allegations of serious compromises in the proper delivery of health and social care services.

10. The above list is not exhaustive and Annex A provides a more comprehensive list.

Key Issues for HPSS Organisations

11. HPSS organisations and Special Agencies should be developing a culture of openness. Policies should be in place to raise awareness and to

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actively encourage the reporting, assessment, management and learning from adverse incidents and near misses. If they have not already done so, all HPSS organisations and Special Agencies should nominate a senior manager at board level who will have overall responsibility for the reporting and management of adverse incidents within the organisation.

12. All HPSS organisations and Special Agencies should have developed, or be developing, centralised systems which facilitate the collection, analysis and reporting of adverse incidents and near misses relating to patients, clients, staff and others. These systems should be capable of supporting an analysis of the type, frequency and severity of the incident or near miss and, where appropriate, should record the action taken.

13. In those situations where a body considers that an independent review is appropriate, it is important that those who will be conducting it are seen to be completely independent. In addition, such reviews should normally be conducted by a multi-professional team, rather than by one individual. It is also important that the Department is made aware of the review at the outset.

Action

14. HPSS organisations and Special Agencies should continue to use established local or national reporting and investigation mechanisms to manage adverse incidents. This will include, where appropriate, notifying other agencies such as the Police Service, the Health and Safety Executive, professional regulatory bodies or the Coroner. Where there is any doubt as to which agencies should be notified, advice should be sought from the Department.

15. The Department will expect urgent local action to be taken to investigate and manage adverse incidents.

16. In addition, where a **serious** adverse incident occurs, it should be reported immediately to the senior manager with responsibility for the reporting and management of adverse incidents within the organisation. If the senior manager considers that the incident is likely to:

- **be serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **be of public concern; or**
- **require an independent review,**

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he/she should provide the Department with a brief report, using the proforma attached at Annex B, within 72 hours of the incident being discovered. The report should be e-mailed to [redacted]. In cases where e-mail cannot be used, the report should be faxed on [redacted]

Action by the Department

17. The Department:

- will collate information on incidents reported to it through this mechanism and provide relevant analysis to the HPSS;
- may also, where appropriate, seek feedback from the relevant organisation on the outcome of the incident to determine whether regional guidance is needed;
- may, in independent reviews, provide guidance in relation to determining specialist input into such reviews.

Enquiries

18. Any enquiries about this Circular from the nominated senior manager should be made, in the first place, to Jonathan Bill, Planning & Performance Management Directorate, on [redacted] or by e-mail at [redacted]

19. This guidance will be reviewed once the Safety in Health and Social Care Steering Group has concluded its work, at which point further, comprehensive, guidance will be issued. In the meantime, the Department will welcome feedback on the issues covered in this guidance. This should be addressed to Jonathan Bill on the e-mail address above, or to Room D2.3, Castle Buildings, Stormont, Belfast, BT4 3SQ.

Yours sincerely

[redacted]

NOEL McCANN
Director of Planning & Performance Management

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

ANNEX A

SERIOUS ADVERSE INCIDENTS - EXAMPLES

The following are examples of serious adverse incidents. It is not an exhaustive list and is intended as a guide only. Where there are any doubts about an incident it should be reported.

Major Incidents

- Any circumstance which necessitates the activation of an HSS Trust, HSS Board or wider community Emergency Plan

Clinical incidents

- Any clinical incident whose consequences would be regarded as severe
- Serious drug events which might require regional or national guidance, to prevent occurrence or reoccurrence within HPSS/NHS organisations, e.g. maladministration of a spinal medicine, major prescription error causing, or with the potential to cause, serious damage or death of a patient

Court Proceedings

- Any incident which might give rise to serious criminal charges
- Impending court hearing, including Coroners' Inquests, or out of court settlement in cases of large scale litigation
- Legal challenges to the HSS Trust or HSS Board

Incidents involving staff

- Serious complaints about a member of staff or primary care contractor
- Serious error or errors by a member of staff or primary care contractor
- Significant disciplinary matters (e.g. suspensions of staff)
- A serious breach of confidentiality
- Serious verbal and/or physical aggression towards staff

Mortality/morbidity incidents

- Clusters of unexpected or unexplained deaths
- The suicide of any person currently in receipt of health and personal social services on or off HPSS premises, or who has been discharged within the last twelve months.
- Death or injury where foul play is suspected
- Situations when a patient or patients require(s) additional intervention(s) as a result of serious failures in diagnostic processes

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- The accidental death of, or serious injury to, a patient, a member of staff, or visitor to HPSS or primary care premises, or involving HPSS or primary care staff or equipment
- Significant harm to children where reported under child protection arrangements
- Vulnerable adult abuse

Premises/equipment incidents

- Serious damage which occurs on HPSS premises or premises on which primary care services are delivered, or to HPSS property or property on which primary care services are delivered, or any incident which results in serious injury to any individual or serious disruption to services (e.g. evacuation of patients due to fire)
- Failure of equipment so serious as to endanger life, whether or not injury results
- Suspicion of malicious activity e.g. tampering with equipment
- Circumstances that lead to the provider no longer being able to provide an element of service

Mental Health or Learning Disability incidents (including substance misuse services)

- The disappearance, absence without leave or absconding of a patient (whether or not detained under the Mental Health Order 1986) where there is serious cause for concern
- Escapes by patients (whether or not detained under the Mental Health Order 1986) from secure accommodation/area
- Homicide, or suspected homicide, by any patient who has received mental health services
- Unexpected death
- All deaths within secure settings
- All deaths of persons who are subject to the Mental Health Order or equivalent legal restriction who has or is receiving mental health service care and treatment
- Any serious criminal acts involving patients, or staff
- An incident that causes serious harm that places life in jeopardy
- Serious injury, resulting in the need for emergency medical treatment via an A&E department, sustained by patient, staff or visitor on HPSS property
- Where a member of staff is suspected of harming patients or serious fraud
- Hostage taking, mass / organised disturbance
- Any omissions/failings of security systems/procedures that jeopardise security
- All incidents reported to or involving the police

ANNEX B

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation:
2. Brief summary (and date) of incident:
3. Why incident considered serious:
4. Action taken:
5. Is any regional action recommended? (if so, full details should be submitted) Y/N -
6. Is an Independent Review being considered? (if so, full details should be submitted) Y/N -
7. Other Organisations informed **PSNI** Y/N - **Coroner** Y/N - **NIHSE** Y/N - **HSS Board** Y/N - **Other** (please specify) Y/N -
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive)

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk

If e-mail cannot be used, fax to (028) 9052 8126

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

Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phoblí

Subject:
Reporting and follow-up on serious adverse incidents

Circular Reference: HSS (PPM) 02/2006

Date of Issue: **20 March 2006**

For action by:

- Chief Executives of HSS Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Officers, HSS Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and Trusts
- Directors of Dentistry in HSS Boards and Trusts
- Directors of Pharmacy in HSS Boards and Trusts
- Directors of Nursing in HSS Boards and Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSS Trusts
- Chairs, Local Health and Social Care Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission

Summary of Contents:

The purpose of this Circular is to notify a number of important points about the reporting and management of Serious Adverse Incidents (SAIs)

Enquiries:

Any enquiries about the content of this Circular should be addressed to:

Quality & Performance Improvement Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005

Superseded documents

Circular HSS4 (OS) 1/73 - Notification of Untoward Events in Psychiatric and Special Care Hospitals

HSS (THRD) 1/97 - Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability

Annexes A and B to Circular HSS (PPM) 06/04

Status of Contents:

Action

Implementation:

Immediate

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Noel McCann
Director of Planning & Performance Management

Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Tel: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

Circular HSS (PPM) 02/2006

20 March 2006

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

For information:

Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS

Introduction

1. Circular HSS (PPM) 06/2004, issued in July 2004, introduced new interim reporting procedures for serious adverse incidents (SAIs) and near misses for HSS Boards, Trusts, Agencies and Family Practitioner Services. Since then, the Department has been monitoring the operation of the system and the purpose of this circular is to notify a number of important points about the reporting and management of SAIs.

2. In particular, this guidance:

   - draws your attention to certain aspects of the process which need to be managed more effectively;
   - notifies important changes in the way that SAIs should be reported in future; and
   - provides a revised report pro forma which should be used in all future reports.

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

3. This guidance also clarifies the processes that the Department has put in place to consider SAIs notified to it and outlines the feedback that will be made available to the HPSS.

Areas for improvement

4. On the basis of the review that the Department has undertaken, it is clear that a number of areas need to be improved:

Nominated Reporting Officers - for an HPSS organisation to comply with the current risk management controls assurance standard, the senior manager at board level with overall responsibility for the reporting and management of adverse incidents should consider the incident against the criteria set out in HSS(PPM) 6/2004. Having a nominated officer at board level provides assurance that incidents are being dealt with appropriately. However, the Department is concerned to note that incidents continue to be reported from a variety of sources within some organisations (in some cases, causing duplicate reporting). This potentially undermines the development of a coherent, co-ordinated and effective approach to incident management within organisations.

It is recognised that circumstances differ in the primary care environment. However, the principles of having a nominated lead to co-ordinate the reporting of incidents is just as relevant. As part of having effective governance arrangements, practices should report SAIs to their area HSS Board. Therefore it is important that both HSS Boards and practices have a nominated lead. It is recognised that different terms are used to mean the same thing in primary care, such as significant events, critical incidents or untoward events. Those events or incidents which occur at practice level and which can be classified as SAIs, should be communicated, within the specified timeframe, by the practice to the relevant HSS Board in the first instance. The HSS Board is responsible for the onward report to the Department of those events or incidents which meet the definition of an SAI. This will include specifying which criteria in HSS (PPM) 06/2004 is relevant in the context of the incident.

The arrangements in place within your organisation should be reviewed to ensure that incident management is co-ordinated and working effectively and that your designated senior manager is aware of those incidents reported to the Department as SAIs and that each meets the criteria set out below.

Appropriate reporting – whilst this circular relates to the reporting of SAIs to the Department, it should be noted that organisations should continue to follow existing reporting mechanisms in order to fulfil their statutory obligations (for example to RQIA or MHC(NI)) and national or local reporting commitments (such as National Confidential Enquiries or under *Co-operating to Safeguard Children*).

HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

- be serious enough to warrant regional action to improve safety or care;
- be of public concern (such as serious media interest); or
- require an independent review.

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A number of incidents reported do not fall into these categories. Although the Department continues to encourage organisations to use the SAI reporting system - and would advise organisations to report if in any doubt – there is a need to ensure that reports made to the Department are serious **and** fall within one or more of the categories set out above.

Children's Homes - in particular, the Department is receiving a substantial number of reports about children who go missing without permission from children's homes. A follow-up report usually arrives (within 24 hours) confirming that the child has been located. Schedule 5 to the Children's Homes Regulations sets out the statutory requirements for notification of such cases. **The Department should only be notified if the criteria set out above apply**. In particular, if an organisation intends to contact the media to assist it in locating a child or if a felony is suspected, the Department should be informed under the SAI reporting system, prior to notification being made to the media. In all other cases, unless they fulfil the SAI reporting criteria, incidents about children who go missing without permission should not normally be reported to the Department.

Confidentiality - incident reports sometimes include details about patients' or clients' names. This practice should be discontinued. All incident reports should be anonymised – generally the gender and age of the patient or client is sufficient detail. To aid any follow-up enquiries, however, you should provide the organisation's incident identifier number.

Delay in Reports - unless there is reasonable justification, a report to the Department should be submitted within 72 hours of the incident being discovered. Where an incident involves the death of a person every effort should be made to submit a report within 24 hours. There has been a number of incidents where the time delay in reporting has been considerable; in some cases, these have been accompanied by an explanation for the delay. Some, however, have failed to provide any explanation.

Electronic Reporting - some organisations have indicated concerns about reporting SAIs by e-mail, chiefly on the basis of uncertainty as to whether the information has been received by the Department. The SAI electronic system has a dedicated e-mail address which is regularly checked. However, in order to provide an additional assurance to the reporting organisation, a response acknowledging receipt of an incident report will in future be issued to the sender's e-mail address. If an organisation fails to receive such a response within 24 hours, it should contact the Department to ensure that the incident report has been received.

Revised Notification Arrangements

5. Previous guidance indicated that, until further notice, HPSS organisations should continue to use existing reporting systems alongside the SAI procedures introduced in 2004. In order to reduce duplication, however, it has been decided to discontinue the requirement to submit separate notifications to the Department in the case of untoward events in mental health, learning disability, nursing and residential homes and child care. When an SAI report is received on these issues, it will be forwarded to the relevant point within the Department. Existing guidance, contained in Circulars HSS4 (OS) 1/1973 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/1997 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability) is now discontinued.

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6. All other existing reporting systems should continue to be used.

Amendments to the SAI Report Proforma

7. The SAI Report proforma (formerly attached as Annex B to Circular HSS (PPM) 06/04) has been revised and is set out in the Annex to this letter. The additional elements are:

- Box 1 - provision for the organisation's own incident identifier number – this will facilitate easier tracing should the Department need to seek further information about the incident.
- Box 2 – in completing this section, reference should be made to any previous SAIs reported which are connected to this particular incident.
- Box 3 – now displays the SAI criteria for reporting to the Department and asks for an explanation as to why the incident meets the criteria.
- Box 4 – extended to include the incident classification as initially assessed by the organisation.
- Box 5 – extended to include the question "Are there any aspects of this incident which could contribute to learning on a regional basis?".
- Box 7 – inclusion of RQIA and facility to record the date on which other organisations are notified. ***Trusts and practices should note that all SAIs should be reported to their commissioning HSS Board as a matter of course***. These reports will help inform HSS Boards with regard to meeting their statutory duty of quality on the services they commission by providing an overview of the quality of service provision and, where appropriate, will facilitate regional learning. In the case of primary care practices, HSS Boards should report to the Department those 'significant events' which are SAIs and fall within the criteria of HSS (PPM) 6/2004.
- Box 8 – as outlined above, it is important that the Chief Executive and the designated senior manager is aware of the incident before the report is submitted to the Department.

Learning from Adverse Incidents

8. The Serious Adverse Incident process is not a performance management tool. However, a key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved. The Department has, therefore, put in place arrangements to review incidents reported to it on a regular basis and to feed back relevant analysis to the HPSS. In this context, the Serious Adverse Incident Group in the Department meets on a monthly basis to consider reports submitted. It may seek clarification from organisations on the outcome of incidents to determine whether regional guidance is needed. In the case of independent reviews, the Department may also provide guidance as to specialist input into such reviews.

9. In June 2005, the Department provided a first regional briefing on SAIs, focusing on the key issues emerging from incidents reported until then. A further briefing event will take place later this year. Additionally, the Department intends to publish a report later this year which will summarise the key issues emerging and recurrent problems being encountered across the region. It is intended that this will assist organisations to review their clinical and social care governance processes, strengthen their incident reporting arrangements and improve the quality of services.

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Action

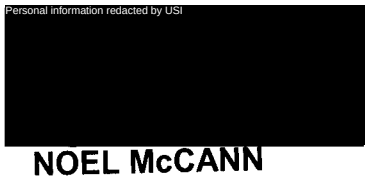
10. All HPSS organisations are requested to:

- note the areas for improvement identified at paragraph 4 above and ensure that action is taken to address these;
- review the arrangements in place within organisations to ensure that incident management is co-ordinated and working effectively, that designated senior managers are aware of those incidents reported to the Department as SAIs and that such incidents meet the criteria set out in paragraph 16 of HSS (PPM) 06/2004;
- note that existing procedures (under 1973 and 1997 guidance) for the notification of untoward events in mental health services and learning disability are now discontinued;
- cancel Circulars HSS4 (OS) 1/73 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/97 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability);
- note the amendments that have been made to the SAI Report Pro-forma; and
- ensure that the revised Pro-forma is brought into use immediately.

11. This Circular will be reviewed in 2007.

12. A copy of this Circular is being sent to designated senior managers responsible for incident reporting in HSS Boards, Trusts and Agencies.

Yours sincerely



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ANNEX

SERIOUS ADVERSE INCIDENT REPORT			
1. Organisation: **Incident Identifier No.**			
2. Date and brief summary of incident:			
3. Why incident considered serious: (i) warrants regional action to improve safety or care within the broader HPSS; (ii) is of public concern; or (iii) requires an independent review.	**Briefly, explain why this SAI meets the criteria:**		
4. Immediate action taken: **Classification of incident as initially assessed by organisation: Catastrophic / Major / Moderate / Minor / Insignificant**			
5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted): **Are there any aspects of this incident which could contribute to learning on a regional basis?**			
6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):			
7. Other Organisations informed:		**Date informed**	Other (please specify) Y/N
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		**Date informed:**
RQIA	Y/N		
8. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*) **Report submitted by:** (name and contact details of reporting officer) **Date:**			

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 8126

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Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety
An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Your Ref:
Our Ref: HSS (PPM) 05/05

Date: 10 June 2005

For Action (with enclosures):

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies

For information (without enclosure):

Chief Executive, HPSS Regulation & Improvement Authority
Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services/Social Work in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

Dear Colleague

REPORTING OF SERIOUS ADVERSE INCIDENTS WITHIN THE HPSS

Introduction

1. Circular PPM 06/04, issued in July 2004, provided interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses.

2. The purpose of this Circular is to provide an update on safety issues; to underline the need for HPSS organisations to report serious adverse incidents and near misses to the Department in line with Circular PPM 06/04; and to request details of senior managers who have been assigned overall responsibility for the reporting and management of adverse incidents.

INVESTOR IN PEOPLE

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Update on Safety Issues

Safety Group

3. The Department established a Safety in Health and Social Care Steering Group initially to advise on the future role and function of the Northern Ireland Adverse Incident Centre (NIAIC), with particular emphasis on the establishment of NIAIC accountability boundaries. However, the Steering Group considered that there was a need for the Department to take a broader, more systematic approach to safety within the HPSS and to provide greater strategic direction on the recording, reporting and investigation of all adverse incidents and near misses.

4. As part of this work, the Steering Group commissioned Deloitte to carry out a scoping exercise on adverse incidents and near miss reporting in the HPSS and special agencies; and to evaluate the Northern Ireland Adverse Incident Centre.

Key Findings of Deloitte Report

5. The Deloitte report acknowledged that, within HPSS organisations, there is a consistent drive to improve the reporting and management of adverse incidents, based on a common belief and understanding of the benefits it can bring to patient and client safety and care. However, the report also noted inconsistencies in approach, including incident reporting systems, monitoring, collation, analysis and follow-up.

6. The report's key recommendations included the need for:

- a consistent approach to the definition and coding of adverse incidents and near misses;
- more Departmental guidance on risk assessment, reporting structures and links to other organisations;
- the development of improved reporting systems to support the analysis and audit of incidents and the development of mechanisms to improve learning and knowledge;
- links between local reporting arrangements and national, statutory, and confidential reporting mechanisms;
- the development of guidance on local investigations and reviews; and
- improved training and development of staff in the use of risk assessment tools, such as root cause analysis.

Further Work

7. In line with these proposals, a number of projects are now being taken forward by the Department. These include:

- work to standardise definitions and coding;
- the development of formal links with the National Patient Safety Agency; and
- the development of a safety framework for the HPSS.

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8. Further information about progress with each of these projects will be issued at a later date.

Reporting Incidents

9. Circular HSS (PPM) 06/04 indicated that the Department, in collating information on serious adverse incidents and near misses, would feed back relevant analysis to the HPSS. In line with this undertaking, a small group has been established in the Department, which reviews all incidents that are notified. It is planned that regular feedback will be issued to the HPSS, including an annual report.

10. As the first step in this process, a briefing session has been arranged for safety managers on 15 June, when the Department will be providing feedback on the operation of the reporting and management arrangements established by Circular PPM 06/04.

11. In the meantime, it is important that notifications required under the interim guidance should continue to be provided to the Department. Safety managers should review the operation of local procedures on a regular basis to ensure that all serious adverse incidents are being reported to the Department.

12. All HPSS organisations are reminded that incidents which are regarded as falling in any of the categories below should be notified to the Department in accordance with the procedures outlined in the guidance:

- **incidents regarded as serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **incidents which are likely to be of public concern;**
- **incidents which are likely to require an independent review.**

13. All other existing systems should continue to be used. In particular, HPSS organisations should continue to report incidents involving medical devices and equipment to the NIAIC.

Management Arrangements

14. Circular PPM 06/04 indicated that HPSS organisations and Special Agencies should be developing a culture of openness. In that context, it requested all HPSS organisations and Special Agencies to nominate a senior manager at board level who would have overall responsibility for safety and the reporting and management of adverse incidents within the organisation. To assist with future communications on safety issues, the Department has decided to establish a central list of these safety managers.

Action

15. A copy of the Deloitte Report is enclosed for your information; also enclosed is a specific section relating to your Trust, Board or Special Agency as appropriate. Taken together, these should be used to inform the safety agenda within your organisation.

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16. Chief Executives of Boards, Trusts and Special Agencies should ensure that copies of the Deloitte Report are available for distribution as appropriate.

17. In line with paragraph 14 above, I should be grateful if you would let Jonathan Bill [redacted] have details of your safety manager – their name, position and contact details, **by 30 June 2005**.

Yours Sincerely

NOEL McCANN

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

FROM THE ACTING CHIEF MEDICAL OFFICER
Dr Ian Carson

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

HSS(MD) 12/2006

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24 MAY 2006
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Castle Buildings
Stormont Estate
Belfast BT4 3SR
Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Your Ref:
Our Ref: iwc
Date: 24 April 2006

TO:- Chief Executives of:
HSS Trusts and Boards
NI Blood Transfusion Service
Central Services Agency
NI Postgraduate Education Council
NI Social Care Council
NI Medical and Dental Training Agency
NI Guardian ad Litem Agency and
NI Medical Physics Agency

For onward transmission by the Chief Executive to relevant staff including:

Executive Leads Governance / Clinical and Social Care Governance
Executive Leads Adverse Incident Management
Governance / Clinical and Social Care Governance/ Risk Managers
Medical Directors
Directors of Nursing
Directors of Social Services
Directors of Pharmaceutical Services
Directors of Public Health
Directors of Primary Care

Dear Colleague

GUIDANCE DOCUMENT – "HOW TO CLASSIFY INCIDENTS AND RISK"

Introduction

I attach a copy of "*How to Classify Incidents and Risk*" as guidance to assist HPSS organisations in developing or reviewing processes to assess adverse incidents and their risk implications. The purpose of the guidance is to act as a model that can be adapted for local use. The target audience for this document is senior managers and those involved in adverse incident management.

Background

This guidance is the product of a wider project that was convened in 2005, under the auspices of the Safety in Health and Social Care Steering Group, to enhance systems and processes in the HPSS to better manage adverse incidents and risk arrangements. It is designed to promote greater consistency of approach within the HPSS and to make it easier for the HPSS to share learning from adverse incidents. The project also fits into the wider context of *HPSS Controls Assurance Standards (*in particular, the criteria concerning adverse incident management), *The Quality*

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Standards for Health and Social Care (specifically the theme of "Safe and Effective Care") and the recently issued *Safety First: A Framework for Sustainable Improvement in the HPSS.*

The project team, lead by the Regional Governance and Risk Management Adviser, consists of clinical and social care governance managers and risk managers from across the HPSS. The project work is quality assured by HPSS Clinical and Social Care Governance Executive Leads.

Action
Organisations will have already set up a centralised system for collating and analysing all adverse incidents. The attached document provides a steer for how these incidents are defined and how they should be analysed; however, each HPSS organisation will need to tailor this advice to best suit their own organisational needs and requirements.

It is recommended that the content and applicability of this document be discussed at senior management level within your organisation. It is not intended that this guidance be used without adaptation to the specific requirements of each organisation. For example; the flowchart contained within the guidance (Page 3) can be used to review existing procedures and can be altered to suit the many different situations that exist across the HPSS.

Future Pathway
This project has two further phases:-

- → Phase II will produce a Regional Minimum Dataset and will be completed within the next few months; and
- → Phase III will produce a set of regional codes for adverse incidents and will be completed in March 2007.

The above work is seen as complementary to any future link with the National Patient Safety Agency (NPSA).

I would like to take this opportunity to thank the project manager, Heather Shepherd, Regional Governance and Risk Management Adviser and her HPSS-wide project team for their effort in putting together this complex work.
The document will be kept under review with the most up-to-date version available from the departmental governance webpage on
http://www.dhsspsni.gov.uk/index/hss/governance.htm

Yours sincerely

DR IAN CARSON
Chair of the Safety in Health and Social Care Steering Group

This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at http://extranet.dhsspsni.gov.uk or by going through the HPSS Web at http://www.n-i.nhs.uk and clicking on DHSSPS.

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How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management

April 2006

This document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

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Contents

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

Introduction

1.1 This document has been produced to assist Health and Personal Social Services organisations (HPSS) in their clinical and social care governance arrangements. In particular to help develop or review processes to assess adverse incidents and their risk implications. It has been written for senior managers responsible for the reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the systems and processes that HPSS organisations currently use to manage incidents. This document has been designed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 Organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The aim of this document is to facilitate better systems for sharing learning from incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from incidents where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included: for example, social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

1.7 Further associated work in this area will include the development of a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

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2.0 Stages of Adverse Incident Management (To be read in conjunction with Flowchart One)

This section provides further guidance to support Flowchart One overleaf and gives further detail relating to each stage in the process.

Stage 1 – Incident occurs and is reported via the organisation's internal reporting mechanism to the organisation's central recording system. Incident details are also communicated internally as necessary.

Stage 2 – Determine actual incident severity (using Table 1 and Table 2). An incident will often have multiple aspects – considering all these aspects (see Table 2) decide the level of severity.

Stage 3 – Assess incident to determine immediate action required. Following this initial assessment consider whether it is appropriate to report to external organisations (See examples of organisations requiring reports in Flowchart One). If the severity of the incident means that action must precede investigation – go straight to Stage 6.

Stage 4 – Initiate incident investigation as appropriate. Following investigation re-consider in the light of further information whether it is appropriate to report to external organisations. (See sample list of organisations that may require reports in Flowchart One).

Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe. (Use the Impact Table – Table 2)
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (Page 6) to determine the overall risk rating.

Stage 6 – Use the Action Guidance (Table 3) to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register and/or any organisation-wide action is required.

Stage 7 – Determine any learning from the adverse incident and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations review the risk rating in Stage 5 and keep this under regular review.

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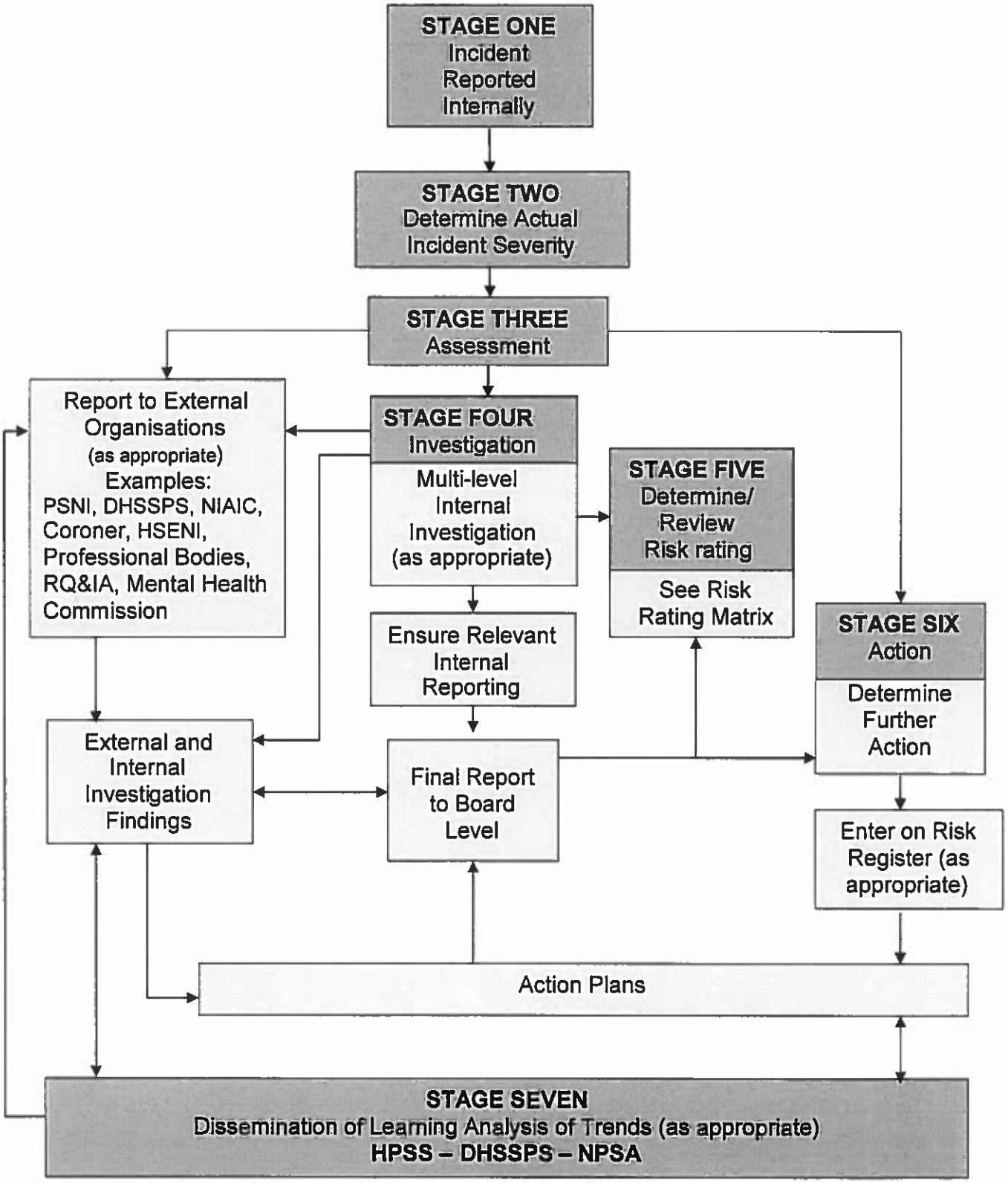
STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE

(please read in conjunction with commentary on Page 2)



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3.0 Initial Grading of Incident Severity

The initial assessment of an incident should be performed quickly, even when all facts may not be available. There is always scope to re-grade as facts and issues emerge over time and following investigation. This guidance is primarily for internal reporting mechanisms but please note one particular external reporting route - Serious Adverse Incidents (most probably incidents from the Catastrophic and Major severity levels) should be reported to the DHSSPS (see Circular HSS (PPM) 02/06) - i.e. those incidents that meet the following criteria:

- Be serious enough to warrant regional action to improve safety or care;
- Be of public concern; or
- Require an independent review.

Table 1 - Actual Incident Severity (according to the facts available)

In determining the actual severity consider the outcome of the incident in terms of harm to people / resources / environment / reputation / quality.

Severity of incident	High Level Descriptors (see Impact Table 2 overleaf for a more detailed list)
Catastrophic	Incident with widespread implications to services
Major	Significant disruption to services
Moderate	Short term disruption to services
Minor	No interruption to services
Insignificant	No adverse outcome but risk potential evident

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Impact Table 2 (based on facts available about the incident)

This table may also be used to assess the impact of risks in order to analyse future risks

	PEOPLE (Any person affected by an Incident: Staff, User, Visitor, Contractor)	RESOURCES (Premises, money, equipment, Business interruption, problems with service provision)	ENVIRONMENT (Air, Land, Water, Waste management)	REPUTATION (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	QUALITY AND PROFESSIONAL STANDARDS (including government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that lead to one or more deaths	Severe organisation wide damage/ loss of services /unmet need	Toxic release affecting off-site with detrimental effect requiring outside assistance.	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities
MAJOR	Permanent physical/emotional injuries/trauma/harm.	Major damage, loss of property / service /unmet need	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident/complaint. Criminal prosecution /prohibition notice	Repeated failure to meet external standards.
MODERATE	Semi permanent physical/emotional injuries/trauma/harm (recovery expected within 1 year).	Moderate damage, loss of property / service /unmet need	On site release contained by organisation	Damage to public relations. Internal investigation (high level), into an incident/complaint. Civil action	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury/harm. Emotional distress. (Recovery expected within days /weeks.)	Minor damage, loss of property / service /Unmet need	On site release contained by organisation	Minimal risk to organisation. Local level internal investigation into an incident/complaint Legal challenge	Single failure to meet internal standards or follow protocol.
INSIGNIFICANT	No injury/harm or no intervention required / near miss	No damage or loss, no impact on service Insignificant unmet need	Nuisance release	Minimal risk to organisation, Informal complaint	Minor non compliance,

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RISK RATING MATRIX (adapted from AS/NZ 4360, 2004 MODEL)

LIKELIHOOD	CONSEQUENCE (Potential Impact)				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (will undoubtedly recur, a persistent issue)					
Likely (will probably recur, not a persistent issue)					
Possible (may recur occasionally)					
Unlikely (do not expect it to happen again)					
Rare (can't believe it will ever happen again)					

Risk Rating

Low	Medium	High	Extreme

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Table 3 - Action Guidance

Risk Rating Level	Descriptors
Extreme	Identified risks which fall in the red area are deemed extreme risk to the organisation and must be reported to the appropriate Governance Group. These risks require immediate action to reduce the level of risk and the relevant Director / Officer will ensure they are forwarded to the Executive Management Board/Governance Committee. The appropriate Director / Officer will ensure the implementation of a time monitored action plan and provide regular reports to the Executive Management Board/Governance Committee.
High	Identified risks which fall in the orange area are deemed high risk to the organisation and require prompt action to reduce the risk to an acceptable level. These risks and agreed action plans should be considered by the local Governance Group. Risks that cannot be reduced locally should be forwarded for consideration by the Executive Management Board/Governance Committee.
Medium	Identified risks which fall in the yellow area are deemed medium risk to the organisation and require action to reduce risk to an acceptable level. Responsibility for taking action would normally remain at a local level within the appropriate Directorates/Programmes/Service Areas and monitored by the relevant Local Governance Group and entered on the Directorate Register.
Low	Identified risks which fall in the green area are deemed as acceptable risks and require no immediate action, but must be monitored regularly.

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Appendices

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APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

This project aims to create a standard method of adverse incident reporting across the Health and Personal Social Services including Trusts, Boards and across the Primary Care sector. This will include creating HPSS agreed standard incident definitions, a minimum dataset and recommended reporting form and regional coding of incidents.

Project Reporting Arrangements

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The Project Team

The project team is multi-disciplinary and drawn from across the HPSS. The project has been able to access HPSS best practice in adverse incident management. A list of project team members is set out below:

Dr Kathryn Booth, Medical Adviser, EHSSB GP Unit / DHSSPS
Ms Tracey Boyce, HPSS Medicines Governance Project Manager, Royal Hospitals Trust
Mrs Therese Brown, Risk Management Director, Altnagelvin HSS Trust
Mrs Jacqui Burns, Risk Manager, NHSSB
Ms June Champion, Risk Manager, Royal Hospitals Trust
Dr Martina Hogan, Consultant Paediatrician, Craigavon Area Hospital Group Trust
Mrs Yvonne Kirkpatrick, Governance Manager, Belfast City Hospital Trust
Ms Irene Low, Risk Manager, Ulster Community and Hospitals Trust
Mr Alex Lynch, Governance Manager, Homefirst Community HSS Trust
Ms Marita Magennis, Social Services, Newry and Mourne HSS Trust
Mrs Mairead Mitchell, Assistant Director, Improvement and Governance, North and West Belfast Community Trust
Mr Brian Mullin, Acting APSW, Causeway HSS Trust
Ms Heather Shepherd, HPSS Regional Governance and RM Adviser
Mrs Roberta Wilson, Clinical and Social Care Governance Co-ordinator

Quality Assurance Group

Quality Assurance for the project was arranged via a virtual QA Group comprising governance leads from all HSS Trusts and HSS Boards.

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

APPENDIX B

REFERENCES, CIRCULARS AND GUIDANCE

The following is a list of useful documents providing further guidance in this area.

Being Open. Communicating patient safety incidents with patients and their carers. National patient safety Agency (2005) www.npsa.nhs.uk

Department of Health, Social Services and Public Safety Memorandum of Understanding

Department of Health, Social Services and Public Safety - Safety in Health and Social Care Project – Clinical and Social Care Governance - Deloitte, 31st March 2004

Circular HSS (PPM) 02/2006 – Reporting and Follow-Up on Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls assurance standards – update http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Creating the virtuous circle: patient safety, accountability and an open and fair culture, NHS Confederation 2003.

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

Doing Less Harm; Improving the Safety and Quality of Care Through Reporting, Analysing and Learning from adverse incidents, Department of Health and NPSA Draft August 2001.

Making it happen – A guide for risk managers on how to populate a risk register (CASU, Keele University) www.dhsspsni.gov.uk/hss/governance

National Patient Safety Agency. 2004 Seven Steps to Patient Safety www.npsa.nhs.uk/health/resources/7steps

NIAIC Safety Notice MDEA (NI) 2006/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.
www.dhsspsni.gov.uk/index/hea/niaic

Patient Safety: Towards Sustainable Improvement, Fourth Report to Australian Health Ministers' Conference, Australian Council for Safety and Quality in Healthcare, July 2003

Shipman Inquiry Reports www.the-shipman-inquiry.org.uk/reports

The Bristol Royal Infirmary Inquiry
www.bristol-inquiry.org.uk/final_report/report/sec2chap21_3.htm

The Confidential Enquiry into Maternal and Child Health; the Confidential Enquiry into Patient Outcome and Death; and the Confidential Enquiry into Homicide and Suicide in Hospital www.national-confidential-inquiry.ac.uk/nci/index.cfm

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

Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Phase 2 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular Reference: HSC (SQSD) 08/2010

Date of Issue: 30 April 2010

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NI Blood Transfusion Service
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation and Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of revised arrangements for adverse incident reporting which are being introduced following a review of the existing adverse Incident reporting and learning systems.
The Circular provides guidance on:
(i) the transitional reporting arrangements which will be put in place pending the full establishment of a new Regional Adverse Incident and Learning (RAIL) system, and
(ii) the revised reporting roles and responsibilities of stakeholder organisations.

Enquiries:

Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D 1
Castle Buildings
Stormont
BELFAST

Related documents

DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
Letter from Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 1 November 2005
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
Letter from the Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 11 September 2006
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments
Letter from Chief Social Services Officer 'Serious Adverse Incidents involving Looked After Children in Residential Care entering the Juvenile Justice Centre' , 15 May 2008

Status of Contents:

Action

Implementation:

From 1 May 2010

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

BT4 3SQ
Tel: Personal Information redacted by the USI
E-mail: [redacted]

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

Introduction

In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department and the implementation of the Regional Adverse Incident and Learning (RAIL) model.

The new RAIL model will reflect the statutory responsibilities of Health and Social Care organisations and will introduce a more coherent and comprehensive regional system for reporting incidents. This will ensure that safety messages and regional learning are identified and disseminated in a consistent and effective manner, and will provide a focus on driving improvements in the quality and safety of services through ensuring that important learning is used to inform and improve practice. It will also ensure that the Department and the Minister are informed of significant events in a timely fashion through the establishment of an Early Alert system, and the arrangements for this will be the subject of a separate circular.

The purpose of this circular is to provide specific guidance on:

a) the arrangements which will be in place following the transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency, pending the establishment of RAIL, **Section 1**; and

b) the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department, **Section 2**.

This guidance will take effect from 1st May 2010. These arrangements will remain in place until the full implementation of the RAIL system, at which point they will be reviewed.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely

Personal information redacted by USI

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

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

Section 1: Reporting Serious Adverse Incidents

1.1 This section outlines the revised arrangements for reporting and management of serious adverse incidents, pending the full implementation of the new RAIL system.

Changes to the reporting of Serious Adverse Incidents

1.2 The requirement on HSC organisations to routinely report SAIs to the Department will cease with effect from the 1st May 2010. Those SAIs which have been reported to the Department up until this date will be reviewed by the Department, with a view to transferring responsibility for any follow-up action that may be required to the HSC Board, working with the PHA. However, it is likely that the Department will wish to retain oversight responsibility for a small number of incidents reported prior to 1st May 2010 where it considers there are particular or significant issues in relation to regional learning, and these will continue to be considered by the Department SAI Review Group, which will remain in operation for a limited period of time to facilitate this. Consequently the Department may continue to request appropriate follow-up information from reporting organisations in relation to these particular cases.

1.3 ***Reports to the HSC Board –*** In line with the operational guidance[1] issued by the HSC Board and PHA to HSC Trusts in parallel with this circular, all incidents which meet the criteria for SAIs as defined in this operational guidance should be reported to the HSC Board with effect from the 1st May 2010. Family Practitioner Services should maintain their existing arrangements for reporting SAIs to the HSC Board.

1.4 The HSC Board will acknowledge receipt of each SAI notified to it, and will obtain any necessary professional advice from the appropriate health and social care professional within the PHA or HSC Board. The PHA and the HSC Board will jointly determine whether any immediate action is required. The HSC Board will ensure that all relevant professional disciplines are involved as appropriate in the management of the incident. The HSC Board will request an incident investigation be carried out by the reporting organisation, to be forwarded to it within 12 weeks in line with current practice. In this regard, incident reviews should continue to be conducted and submitted in the format outlined in HSS (MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports, included at Appendix 3 of the HSC Board/PHA operational guidance. In addition, the National Patient Safety Agency's toolkit is available for investigations which require a full root cause analysis[2].

1.5 The HSC Board will establish a system to ensure that the reports of investigations are discussed by relevant multi-disciplinary staff from the HSC Board and the PHA to identify any learning recommendations arising, and the most appropriate methods of sharing and/or disseminating the lessons therein. The HSC Board will liaise with the Department as appropriate regarding the most effective mechanisms for disseminating any regional guidance which may be required.

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[1] http://www.hscboard.hscni.net/lnews/22%20April%202010%20-%20HSCB%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010.pdf

[2] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

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

1.6 HSC organisations will retain their existing responsibility for reporting, managing, investigating, analysing and learning from adverse incidents/near misses occurring within their organisation in accordance with criterion 4 of the core Risk Management Controls Assurance Standard (CAS). The Risk Management CAS is being updated in line with this circular and will be available on the Department's website from June 2010. These responsibilities are described in more detail in **Section 2**. Similarly the HSC Board will retain existing responsibilities with regard to adverse incidents occurring in Family Practitioner Services.

1.7 ***Reports to the Regulation and Quality Improvement Authority (RQIA)*** - RQIA will continue to require incidents to be reported to it in accordance with the new statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission, as detailed in the 2007 UTEC Committee guidance [3]. These include incidents involving ***suspected suicides*** and ***under 18s admitted to adult mental health and learning disability facilities*** as referred to in circular HSC(SQSD) 22/09.

1.8 The RQIA also has extended responsibilities under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Under the 'national preventative mechanism' (NPM), there is a statutory requirement to inform RQIA of the death of any patient or client not resulting from natural causes (including homicides), physical, sexual or other serious assaults and allegations/incidents of abuse in hospital or community services. This should involve, where appropriate, collaborative working with the HSC Board. Further details of RQIA responsibilities in respect of reporting and investigation of incidents are set out in Section 2.

1.9 ***Reporting of suspected suicides -*** From 1st May 2010, SAIs involving suspected suicides are to be reported to both the HSC Board and RQIA in the first instance. However, the management and follow-up of reported incidents with the reporting organisation will be undertaken by the HSC Board and PHA, who will liaise with RQIA in this process.

1.10 ***Reporting of incidents under Children Order Statutory Functions –*** Incidents/events relating to;

(a) the admission of under 18s to adult mental health and learning disability facilities;
(b) children from a looked after background who abscond from care settings, which includes trafficked children and unaccompanied/asylum seeking children;
(c) children from a looked after background who are admitted to the Juvenile Justice Centre or Young Offenders' Centre;
(d) placements outside of the regulated provision for 16-17 year olds; and
(e) serious incidents necessitating calling the police to a children's home

will no longer be reported through the SAI reporting system. With effect from 1st May 2010 such incidents/events should instead be reported directly to the Social Care and Children Directorate at the HSC Board. Details of the arrangements for such notifications are set out in the operational guidance issued by the Social Care and Children Directorate at the HSC Board.

[3] www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

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

1.11 ***Breach of 12 hours A&E standard*** – the Performance Management & Service Improvement Directorate within the HSC Board will continue to monitor breaches of this standard. The reporting of these should be emailed direct to h[Irrelevant redacted by the USI] using the existing proforma.

Section 2: Roles, Responsibilities and Accountability Arrangements for incident reporting pending the establishment of RAIL

Health and Social Care Trusts

2.1 HSC Trusts are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide.

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSC Board/PHA with regard to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm;
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and Health and Safety Executive on investigating patient or client safety incidents[4]) and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board and PHA that the requirements above are being met.

Family Practitioner Services

2.3 Family Practitioner Services are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses within the context of the services that they provide. They will be required to produce evidence of learning as part of their clinical and social care governance arrangements which the HSC Board may use as part of its performance monitoring and service improvement or contractual monitoring arrangements.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice;
- Report to the RQIA and the HSC Board all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last two years;

[4] http://www.dhsspsni.gov.uk/ph_hss(md)_6_-_2006.pdf
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

- Investigate incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally, to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board that the requirements above are being met.

Health and Social Care Board

2.5 In line with the HSC Board's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the Department that these responsibilities are being met and that learning is being implemented. In general terms, the HSC Board is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSC Board and PHA health and social care professionals.

2.6 The HSC Board, working with the PHA, will be responsible for the management of SAI reporting under the arrangements set out in its operational guidance, pending the full implementation of the RAIL system. In addition, the HSC Board is responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.7 The HSC Board is required to:

- Maintain a system to manage SAI reporting, in partnership with the Agency, in line with the arrangements set out in the operational guidance issued in tandem with this circular, pending the implementation of the RAIL system;
- With input from the PHA, hold Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Hold Family Practitioner Services to account for the responsibilities outlined in paragraph 2.4 and provide assurance to the Department that these responsibilities are being met;
- Maintain a system to record and track adverse incidents/near misses that occur within the HSC Board;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met; and
- Participate as a member of the RAIL implementation project.

Public Health Agency

2.8 The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs, pending the full establishment of the RAIL system.

2.9 The PHA will assume lead responsibility for implementing the RAIL system, including securing professional input as appropriate. In addition, the PHA will have responsibility for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.10 The PHA is required to:

- Work with the HSC Board to maintain a system to manage SAI reporting, pending the establishment of the RAIL system;
- Maintain a system to record and track adverse incidents that occur within the PHA;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met;
- Support the HSC Board in holding Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Work collaboratively with the Department and the HSC Board to develop and progress the support structures and processes which will underpin the new RAIL system;
- Be responsible for the operational management of the RAIL system, once established; and
- Nominate the Project Director and provide administrative support for the RAIL implementation project.

Regulation and Quality Improvement Authority

2.11 From 1st April 2009, RQIA assumed responsibility for those incident reporting requirements which were previously the domain of the Mental Health Commission. This includes oversight of adverse incidents occurring within the mental health and learning disability programmes of care, establishing trend analysis and reporting on regional learning from such incidents or issues.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention Against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of persons deprived of their liberty, access all information referring to the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

2.13 The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging its new functions under the HSC (Reform) Act (NI) 2009[5]; and
- Require the HSC Board to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

The Department

2.14 In line with its core functions and the revised accountability arrangements which came into effect from April 2009 following the re-organisation of services as part of the Review of Public Administration, the Department will:

- Continue to host the SAI Review Group for a limited period, and will progress a small number of existing SAIs, along with dissemination as appropriate of any regional learning arising from new incidents;
- Oversee the project management arrangements for the implementation of the RAIL system;
- Seek assurance from the HSC Board/PHA on the effectiveness of the interim incident reporting arrangements within HSC Trusts and Family Practitioner Services;
- Seek assurance from the PHA that it will be in a position to effectively operate the RAIL system, including securing professional input to identifying and cascading regional learning.

[5] 2009 c.1 (N.I.)

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

Timetable for Implementation of RAIL

3.1 It is planned that the RAIL system will be implemented, in partnership with key stakeholders in the process, on a phased basis over the next one to two years, subject to testing of the feasibility, cost and effectiveness of the system.

3.2 As part of the implementation process, a business case for the establishment of the administrative and IT support structures around the RAIL system will be developed, and a number of pilots will be rolled out and tested across the HSC.

Conclusion

3.3 This guidance circular covers the interim reporting arrangements for the initial phase of that implementation process, setting out the roles and responsibilities of all stakeholder bodies in this period, and will be reviewed when the RAIL system is established. Revised guidance will be issued when the new arrangements are in place.

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

Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

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MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

For action by:

- Chief Executives, HSC Trusts
- Chief Executives, HSS Boards
- Chief Executive designate, HSC Board
- Chief Executive designate, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive designate, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Officers, HSS Councils
- Chief Executive designate, Patient and Client Council
- Director of Public Health designate, PHA
- Director of Performance Management designate, HSC Board
- Directors of Social Services in HSS Boards and HSC Trusts
- Directors of Dentistry in HSS Boards
- Directors of Pharmacy in HSS Boards
- Directors of Nursing in HSS Boards and HSC Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSC Trusts
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of the interim arrangements on adverse incident reporting which are being introduced following a review of the existing adverse incident reporting and learning systems.
The Circular provides guidance on the initial phase of the transition arrangements which will be put in place to manage the phasing out of the Department's existing Serious Adverse Incident reporting system, and the establishment of a new Regional Adverse Incident and Learning (RAIL) system.

Circular Reference: HSC (SQSD) 22/2009

Date of Issue: 30 March 2009

Related documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
DS 154/06: Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments

Superseded documents

Status of Contents:

Action

Implementation:

Initial phase: From 01 April 2009

(To be reviewed by 30 June 2009)

Enquiries:
Any enquiries about the content of this Circular should be addressed to:
Safety & Quality Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
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Tel: Personal Information redacted by the USI [redacted]

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Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm

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

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

The current system for reporting Serious Adverse Incidents occurring in health and social care settings to the Department was established in July 2004. That system built upon information systems already established by Trusts on adverse incidents generally. During 2008 the Department carried out a review of the SAI system to ensure that this arrangement for reporting of serious adverse incidents remained fit for purpose and consistent with the new organisational and accountability arrangements due to come into effect from 1 April with the establishment of the new Health and Social Care Board and the Public Health Agency. The Department has worked in partnership with a range of stakeholders across the HSC in the course of this review and has, as a consequence, agreed a new model for the management of learning, especially that of a regional nature, arising from adverse incident reporting. This is to be known as the Regional Adverse Incident and Learning (RAIL) system.

The Departmental Board and the Minister have now endorsed the principles of the RAIL system and the Department will shortly establish project structures, in partnership with HSC stakeholders, to manage the development and implementation of the new RAIL system.

In order to ensure a smooth transition as the new HSC bodies assume their roles and responsibilities, there will be a phased implementation of the new RAIL system which will ultimately entail ending, during this year, the need for reports on Serious Adverse Incidents (SAIs) being sent to the Department by HSC Trusts or the HSC Board.

The purpose of this circular is to provide specific guidance on important initial changes to the operation of the current SAI reporting arrangements during the first quarter of 2009/10. These immediate changes should lead to a reduction in the number of SAIs that are required to be reported to the Department in the interim.

A further circular will issue shortly giving details about the next stage in this phased implementation which will be put in place to manage the transition from the SAI reporting system, through its cessation and then the establishment of the RAIL system.

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

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

The operation of the SAI System during the first quarter of 2009/10

1.1 The establishment of the new regional organisations, the Health & Social Care Board (HSC Board) and the Public Health Agency (PHA), together with the extended remit of the Regulation & Quality Improvement Authority (RQIA) from 1 April, means there will be revised roles and responsibilities in relation to arrangements for the reporting and monitoring of adverse incidents; ensuring that learning has been implemented and shared more widely as appropriate; and in providing assurance to the Department that effective systems are in place. However in order to ensure continuity in reporting arrangements during this transitional phase, the Department's current SAI reporting system will remain in place for a short interim period until the HSC Board and the PHA achieve their full functionality.

1.2 Therefore those adverse incidents and near misses which meet the criteria for reporting to the Department set out in Circular HSC(SQSD) 19/07, should continue to be submitted to the Department in accordance with existing arrangements and within the usual timescales. There will, however, be two exceptions to this, details on which are set out in paragraph 1.3 below.

1.3 From 1 April, revised reporting arrangements will apply in respect of:

(i) ***Suspected suicides*** - Those adverse incidents which meet the statutory requirements for reporting to the Mental Health Commission should now be reported to the Regulation and Quality Improvement Authority, in line with the transfer of functions from the MHC to RQIA, which takes effect from 1 April. The current SAI reporting template may still be used to alert RQIA to these deaths during this interim period.

Consequently, the reporting of suspected suicides through the SAI system to the Department should cease. The Department will continue to consider other SAIs relating to mental health services during this short period, including learning on interface issues with mental health services and it will ensure that this is shared with RQIA; and

(ii) ***Under 18s admitted to adult mental health/learning disability facilities*** – HSS Boards already operate monitoring systems to track admissions and the care being given to these patients. To avoid duplication, there should only be a single channel of notifying these occurrences to the HSC Board and the reporting of these **admissions** as SAIs should be discontinued. However, as part of its extended remit, RQIA will need to be advised when these admissions take place. Therefore the notification that is made to the HSC Board should also be copied to RQIA and should contain sufficient assurance that Departmental guidance[1] is being adhered to with regard to the risk assessment, treatment and care of these young people. This does not, however, preclude the need to report as an adverse incident any occurrence where a patient has come to harm whilst in such a placement.

[1] Under 18 year olds in Adult Mental Health Facilities (DHSSPS, 13 March 2006) and Under 18 year olds in Adult Learning Disability Facilities (DHSSPS, 15 October 2008)

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

1.4 Until further notice, HSC Trusts and Family Practitioner Services should continue to report serious adverse incidents to the new HSC Board using current channels of communication, and in particular, the specific contact points in the four HSS Boards.

The next phase of implementing RAIL during 2009/10

2.1 It is planned that the new RAIL system, to be located in the Public Health Agency, will be implemented, in partnership with key stakeholders in the process, over the next two years, subject to testing of the feasibility, cost and value for money of the system. However the cessation of reporting Serious Adverse Incidents to the Department is expected to be achievable within the next few months.

2.2 A further circular will issue shortly which will focus on the detail of:

(i) managing the phasing out and cessation of the Department's SAI reporting system, and the establishment of a new RAIL system; and

(ii) the roles and responsibilities of the key stakeholders in reporting and managing adverse incidents during the transition period.

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

From the Deputy Chief Medical Officer
Dr Paddy Woods

HSS(MD)1/2016

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

Your Ref:
Our Ref: HSS(MD)1/2016
Date: 13 January 2016

For Action:
Chief Executive, HSC Board
Chief Executives, HSC Trusts
(for distribution to All Governance leads)
Medical Directors, HSC Trusts
(for onward distribution to all Medical Practitioners)
Chief Executive, Public Health Agency
Executive Medical Director/Director Public Health, PHA
Directors of Social Work, HSC Trusts
Directors of Nursing, HSC Trusts
Dr Margaret O'Brien, Assistant Director for GMS, HSCB
All General Practitioners and GP Locums *(for onward distribution to practice staff)*

Dear Colleague

PROCESS FOR REPORTING CHILD DEATHS

TO NOTE:

i) the important changes notified by the Health and Social Care Board, to the Serious Adverse Incidents (SAI) criteria in respect of the reporting of child deaths, which will take effect from 1st February 2016; and

ii) the specific guidance on the process to be implemented within HSC Trusts when a child death occurs.

In October 2013, the requirement to report the death of every child as an SAI was introduced. The rationale behind this change was to provide clarity in terms of reporting all child deaths and to enhance the culture of learning and review. The inclusion of this criterion was also pertinent at the time due to the ongoing Inquiry into Hyponatraemia-related Deaths with the decision to report the death of any child as an SAI welcomed by the Chair of the Inquiry.

The report "The Right Time, The Right Place" by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having "*a detrimental effect on the system*". He also stated that "*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*". Hence, he recommended that, "*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*"

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

The Department, working in partnership with the HSCB and a range of other stakeholders across the HSC, including Trusts and PHA, has agreed to pilot a new process for reviewing and reporting child deaths. This process includes a multidisciplinary review of all child deaths at Mortality and Morbidity (M&M) meetings as a prime method of scrutiny. Trusts will need to ensure that appropriate and proportionate processes are in place to allow every child death to be reviewed at a multidisciplinary mortality and morbidity meeting within eight weeks of the death occurring. Detailed information about the new process is included in the attached appendices.

The HSCB has advised that the mandatory requirement to report the death of a child as an SAI will be removed with effect from 1 February 2016. The pilot period will therefore commence on 1 February 2016 and will run through until 31 January 2017, when an evaluation of the process will be conducted.

Regional Mortality and Morbidity Review System

Simultaneously, the Department is currently introducing for both adults and children a Regional Mortality and Morbidity Review System (RM&MRS) to provide greater assurance of the processes surrounding death certification in Northern Ireland. This will be based on the functionality of the systems and processes already in operation in the BHSCT and the SHSCT. Once complete, this system will allow for the electronic recording and review of **all** deaths in hospitals, with each death being considered as part of an M&M meeting. It is anticipated that this electronic system will be fully operational in all Trusts by April 2017.

Until then, a paper based process to review all child deaths will be introduced in all Trusts, except for the Belfast HSC Trust, which will continue to record all deaths on the M&MRS already in place. The schematic and guidance attached describes the new process to be followed.

Dr Paddy Woods
Deputy Chief Medical Officer

Cc Dr Joanne McClean, PHA
Mrs Heather Reid, PHA
Mrs Anne Kane, HSCB

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

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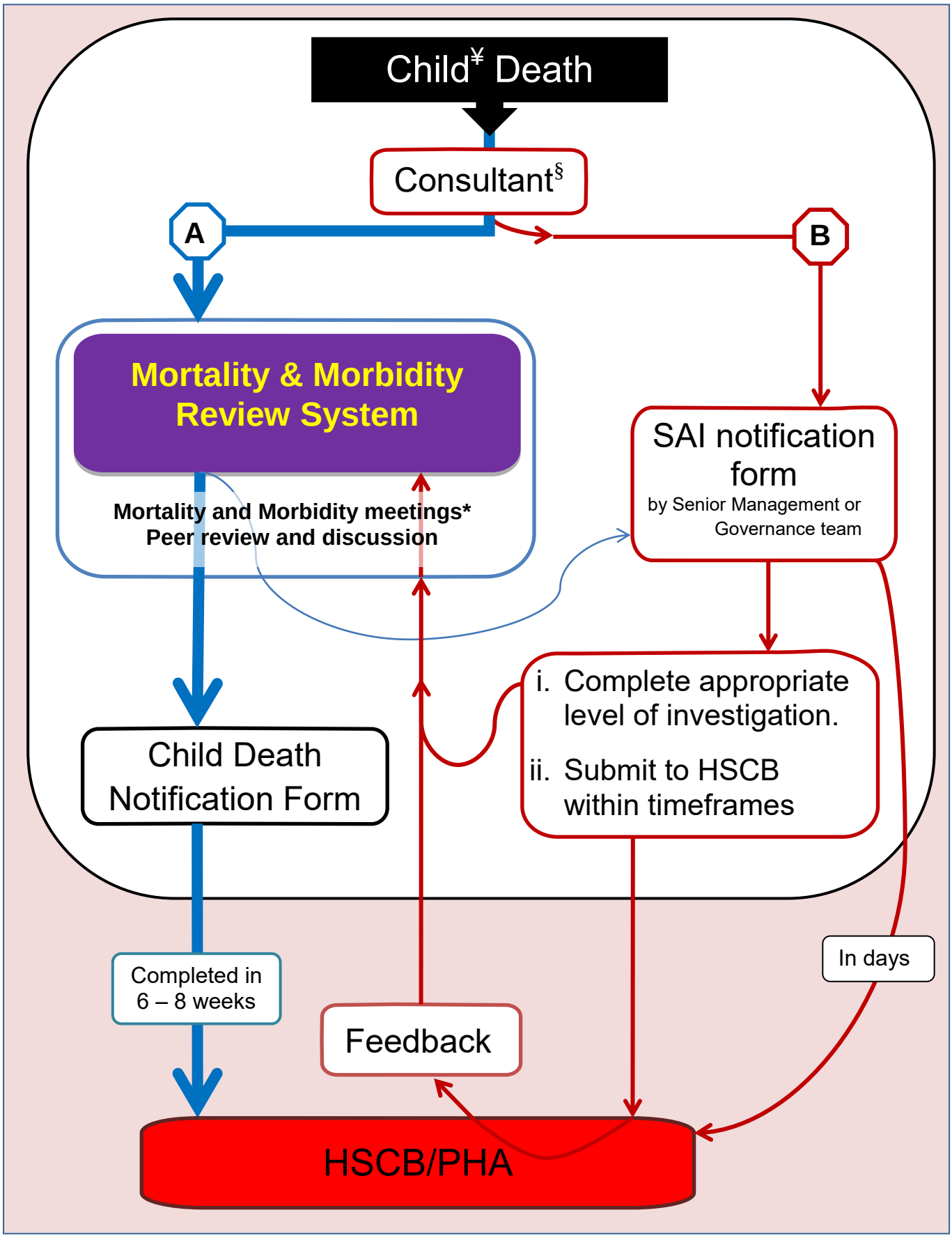
Child Death Review Process Schematic



From the 1st February 2016, the following guidance should be used for all child deaths.

Principles

1. All Child¥ Deaths must undergo a clinical peer review process e.g. M&M meeting.
2. All Child¥ Deaths must have a Child Death Notification Form (CDNF) completed and forwarded to the HSCB/PHA.
3. Where a Child Death has required an SAI investigation, the report's recommendations must be discussed at the next scheduled M&M meeting.

Child¥

This guidance applies to every child up to their eighteenth birthday. This includes babies at any gestational age who are born alive and subsequently die.

Child Death in the Community

The death of a child in the community will require a similar process of clinical peer review to that occurring after a death in hospital. This can be achieved by reviewing the death during a hospital M&M meeting where either the Hospital Consultant (who had cared for the child when in hospital) or the Community Paediatrician takes the lead. There would therefore need to be a robust liaison process between the hospital and community services in these circumstances so that each are aware of the details entered onto the MCCD or given to the Coroner and the exact circumstances of the death. This is to be certain that the hospital clinical peer review covers all aspects of the death, including those features that occurred in the community.

The clinical peer review could also occur in the community if there is a community based clinical peer review process which satisfies HSCB/PHA requirements.

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Process

The revised process for child deaths is outlined in the following pages:

Table 1 is the process for all HSC Trusts to follow, other than Belfast HSC Trust.

Table 2 is the process to be followed by Belfast HSC Trust.

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Table 1	Child Death Reporting Process – ALL Trusts other than BHSCT
Step 0	Following a Child Death, a certifying doctor should, • complete a Medical Certificate of Cause of Death; or, if appropriate, • notify the Coroner; and • notify the Safeguarding Board if the death meets the criteria for a case management review (appendix 1).
Step 1a	For a Child Death that occurs in hospital, which includes all child deaths arriving in the ED e.g. accidents, proceed from step 2a onwards.
Step 1b	For a Child Death that occurs in the community, either a (i) Hospital based clinician e.g. Palliative Care Consultant or Oncologist, responsible for that child, should ensure that they record and peer review the death within their hospital as from step 2a onwards; or a (ii) Community Paediatrician should ensure the death is recorded and that they can peer review the death within a hospital service as from step 2a onwards; or the case has a (iii) Child Death Notification Form completed and a community based peer review meeting held as from step 2a onwards. A Child Death occurring in the community may (rarely) not already be known to Community Paediatricians or have entered the hospital system through ED e.g. Sudden Unexpected Death in Infancy and Childhood (SUDIC). In these cases, it is expected that Consultant Paediatric Pathologists, (if involved), will alert the hospital governance teams who will ensure the death is recorded and peer reviewed.
Step 1c	If a Consultant becomes aware of a Child Death in another jurisdiction, (that was in receipt of HSC services in NI and referred elsewhere for treatment e.g. UK, ROI), they should ensure the death is recorded using the Child Death Notification Form and follow the steps as prescribed below. This Child Death will have already been certified elsewhere or previously notified to the Coroner. Their death should also be reviewed in the other jurisdiction and details of that review will be shared with the referring NI Consultant, for further discussion at an M&M meeting.
Step 2A A	The Consultant[§] should review the circumstances of the death and ensure sections 1 - 5 of the Child Death Notification Form are completed and sent to the designated M&M lead. The designated M&M lead must then schedule the case for review and discussion at the next M&M meeting. These should be held on a regular basis to ensure timely review of all child deaths.
Step 2B B	If the death meets the SAI criteria (appendix 2), the Consultant[§] must also ensure that the SAI process is initiated. At its conclusion, the outcome of the SAI investigation should be communicated through the M&M lead for discussion at the next scheduled M&M meeting.
Step 3	The M&M meeting should be held to review all the child deaths and any completed SAI investigations that have occurred since the previous meeting.
Step 4	The M&M meeting should be multidisciplinary in nature. The M&M lead should lead a review of, i. The clinical details relating to the case including admission diagnosis; ii. The cause of death; * iii. Any avoidable factors identified during the discussions; iv. Any discussion with the Coroner and its outcome; v. Any lessons to be learned, especially of the identified avoidable factors; vi. Actions required including those aimed at repeating any avoidable factors. If information comes to light during the course of the M&M meeting indicating that the case should now be reported as an SAI or to the Coroner, this must be done immediately.
Step 5	Child Death Notification Form sections 6 – 9 should be completed and issued to the HSCB/PHA via the Trust governance team or audit unit.

Table 2	Child Death Reporting Process - BHSCT
Step 0	Following a Child Death, a certifying doctor should, • complete a Medical Certificate of Cause of Death; or, if appropriate, • notify the Coroner; and • notify the Safeguarding Board if the death meets the criteria for a case management review (appendix 1).
Step 1a	For a Child Death that occurs in hospital, which includes all child deaths arriving in the ED e.g. accidents, proceed from step 2a onwards.
Step 1b	For a Child Death that occurs in the community, either a, (i) Hospital based clinician e.g. Palliative Care Consultant or Oncologist, responsible for that child, should ensure that they record and peer review the death within their hospital as step 2a onwards; or a (ii) Community Paediatrician should ensure the death is recorded and that they can peer review the death within a hospital service as from step 2a onwards; or the case has a (iii) Child Death Notification Form completed and a community based peer review meeting held as from step 2a onwards. A Child Death occurring in the community may (rarely) not already be known to Community Paediatricians or have entered the hospital system through ED e.g. Sudden Unexpected Death in Infancy and Childhood (SUDIC). In these cases, it is expected that Consultant Paediatric Pathologists, (if involved), will alert the hospital governance teams who will ensure the death is recorded and peer reviewed.
Step 1c	If a consultant becomes aware of a Child Death in another jurisdiction, (that was in receipt of HSC services in NI and referred elsewhere for treatment e.g. UK, ROI), they should ensure the death is recorded using the Child Death Notification Form and follow the steps as prescribed below. This Child Death will have already been certified elsewhere or previously notified to the Coroner. Their death should also be reviewed in the other jurisdiction and details of that review will be shared with the referring NI Consultant, for further discussion at an M&M meeting.
Step 2A A	ALL child deaths must be recorded onto the M&MR system on the Intranet. The Consultant[§] should review the circumstances of the death, complete the Consultant review section, confirm the record is complete and correct and then sign-off. The case will be forwarded to the next M&M meeting. The designated M&M lead must then schedule the case for review and discussion at the next M&M meeting. They should be held on a regular basis to ensure timely review of all child deaths.
Step 2B B	If the death meets the SAI criteria (appendix 2), the Consultant[§] must also ensure that the SAI process is initiated. At its conclusion, the outcome of the SAI investigation should be communicated through the M&M lead for discussion at the next scheduled M&M meeting.
Step 3	The M&M meeting should be held to review all the child deaths and any completed SAI investigations that have occurred since the previous meeting.
Step 4	The M&M meeting should be multidisciplinary in nature. The M&M lead should lead a review of, i. The clinical details relating to the case including admission diagnosis; ii. The cause of death; ***** iii. Any avoidable factors identified during the discussions; iv. Any discussion with the Coroner and its outcome; v. Any lessons to be learned, especially of the identified avoidable factors; vi. Actions required including those aimed at repeating any avoidable factors. If information comes to light during the course of the M&M meeting indicating that the case should now be reported as an SAI or to the Coroner, this must be done immediately.
Step 5	Once the M&M meeting has finished the review of the case and all the fields of the M&M record have been completed, the Child Death Notification Form report fields should be populated and issued to the HSCB/PHA via the Trust governance team or audit unit.

Notes

§ Consultant

This would ordinarily refer to the Consultant in charge of the patient and/or whoever was involved in the episode of care at the time of the child's death.

It could also be a Clinical Director, the Associate Medical Director or other senior clinician.

It may be a Community based Physician/Paediatrician.

* = For the discussion of ALL deaths which includes deaths,

- reported to the PSNI, Coroner;
- being investigated as an SAI; and
- awaiting findings from a post mortem.

This is to ensure that any learning is disseminated to the clinicians at the M&M meeting as soon as possible. For cases that are being investigated by the Coroner or the PSNI the discussion should be confined to the medical management and clinical matters of that case which require a forum discussion to highlight important matters of learning that clinical staff are aware of.

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HSC Health and Social Care Board | HSC Public Health Agency

rm Identifier	"[H & C number]"

Child Death Notification form

1. CHILD'S DETAILS

Date of birth		If neonate	"[Gestational Age]"

2. DETAILS OF THE DEATH

Hospital / Place of death name	"[Hospital or place of death where child died.]"		
Ward	"[Ward or Unit where child died.]"		
Date of Death		Time:	
Death in the Community or outside NI	"[Details of circumstances]"		

Brief clinical details	"[Enter brief clinical details of case.]"
Admission diagnosis	"[Enter brief admission diagnosis, if known.]"

3. OUTCOME – MCCD details (if known)

MCCD	Cause of Death	Interval
Ia	"[Record exact details as entered on MCCD]"	
Ib	"[Record exact details as entered on MCCD]"	
Ic	"[Record exact details as entered on MCCD]"	
II	"[Record exact details as entered on MCCD]"	

4. OUTCOME - CORONER details

Coroner contacted – 'discussed' – MCCD issued.	"[Yes or No]"	Date	"[date Coroner contacted]"
Coroner notified: - for Coroner's PM.	"[Yes or No]"	Date	"[date Coroner contacted]"
Coroner notified: MCCD/proforma requested.	"[Yes or No]"	Date	"[date Coroner contacted]"
Cause of Death	"[Enter cause of death, if known.]" "[Attach or enter Coroner's verdict when known.]"		

5. FURTHER QUESTIONS

Was there an expectation, realised at the time of admission, that this patient would die during this admission?	"[Yes or No]"
Further details.	"[Enter details here]"
Did the patient receive palliative End of Life Care?	"[Yes or No]"
Did the patient receive treatment from the multi-disciplinary Specialised Palliative Care Team?	"[Yes or No]"

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Form Identifier	"[H & C number]"

6. MORTALITY & MORBIDITY MEETING DETAILS

M&M meeting date	"[M&M meeting date.]"
Discussion details	"[Record brief details of M&M discussion.]"
Lesson learned	"[Details of any lessons learned.]"
Action agreed	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned	"[Details of any lessons learned.]"
Action agreed	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned	"[Details of any lessons learned.]"
Action agreed	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned	"[Details of any lessons learned.]"
Action agreed	"[Details of any action agreed, timescale + who is responsible.]"
Lesson learned	"[Details of any lessons learned.]"
Action agreed	"[Details of any action agreed, timescale + who is responsible.]"

7. FINAL CATEGORISATION

Categorise death using the scale below	"[Enter category number]"

1. There were no areas of concern or for consideration in the management of this patient.
2. There were areas for consideration but they made no difference to the eventual outcome.
3. There were areas of concern but they made no difference to the eventual outcome.
4. There were areas of concern which may have contributed to this patient's death.
5. There were areas of concern which CAUSED the death of this patient who would have been expected to survive.

An area of concern is where it is believed that areas of care should have been better.
An area for consideration is where it is believed that areas of care could have been improved whilst recognising that there may be issues for debate.

8. SERIOUS ADVERSE INCIDENT (SAI) REFERRAL

Has a SAI previously been reported?	"[Yes or No]"	"[SAI incident number.]"
Following a M&M review, has a SAI needed to be reported?	"[Yes or No]"	"[SAI incident number.]"

9. REPORTER DETAILS

Date of Completion	"[Enter date form is completed.]"		
Full name	"[Enter full name of the person completing form.]"		
Title	"[Enter job title.]"		
Organisation:	"[Full Department name.]"	Tele:	"[Full telephone number.]"

E-mail address	"[Email address.]"

Please return this form to: [redacted]

Appendix 1

Safeguarding Board criteria

Regulation 17 of the SBNI Regulations state -

"17.—(1) In exercising its function under section 3(4) of the Act (case management reviews) the Safeguarding Board must undertake a case management review in such circumstances as are described in paragraphs (2) and (3).

(2) Where —

(a) a child has died or been significantly harmed;

(b) any of the following apply–

(i) abuse or neglect of the child is known or suspected;

(ii) the child or a sibling of the child is or has been placed on the register maintained by a HSC trust which lists each child resident in the area of the trust who, following an investigation by that trust under Article 66 of the Children (Northern Ireland) Order 1995(1), is subject to a plan to safeguard that child from further harm and promote his health and development; or

(iii) the child or a sibling of the child is or has been looked after by an authority within the meaning of Article 25 of the Children (Northern Ireland) Order 1995;

(c) the Safeguarding Board has concerns about the effectiveness in safeguarding and promoting the welfare of children of any of the persons or bodies represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the Act; and

(d) the Safeguarding Board determines that there is significant learning to be gained from the case management review which, if applied effectively, will lead to substantial improvements in practice in safeguarding and promoting the welfare of children in Northern Ireland

(3) Where the Safeguarding Board has determined that a case demonstrates that any of the persons or bodies represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the Act, have worked effectively (individually or in partnership) and that there is outstanding positive learning to be gained from the case which will lead to improved practice in safeguarding and promoting the welfare of children across Northern Ireland.

It should be noted that all four strands of **Regulation 17(2)** [(a), (c) and (d), and at least one element of (b)] must be satisfied for the requirement for a CMR to be triggered, that is, in circumstances where a child has died or been significantly harmed.

Notifications should be made to: [redacted] Irrelevant redacted by the USI

Appendix 2

4.0 DEFINITION AND CRITERIA (as at 1 February 2016)

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident.

4.2 SAI criteria

4.2.1. serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3. unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4. serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5. serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare*

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

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services) and/or learning disability services, in the 12 months prior to the incident;

4.2.6. suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

HSCB/PHA Contacts

SAI
Mrs Anne Kane
Governance Manager
Health and Social Care Board
Tel: Personal Information redacted by the USI

Child Death Notifications
Dr Joanne McClean
Consultant in Public Health Medicine
Public Health Agency
Personal Information redacted by the USI

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Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

SAFETY FIRST:
A Framework for Sustainable Improvement in the HPSS

March 2006

Produced by:
Department of Health, Social Services and Public Safety
Castle Buildings
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Contents

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POLICY STATEMENT ON SAFETY

The Department of Health, Social Services and Public Safety, together with the Health and Personal Social Services (HPSS), is committed to the ongoing development of a safer service, as part of its drive to improve clinical and social care, service user experience and outcomes.

No health and social care environment will ever be absolutely safe and without risk; however, more can always be done to improve the safety and quality of care provided.

High safety standards are key indicators of a high quality service. Over the next few years, the policy focus will be on linking quality and safety. Particular attention will be on:

- Creating an informed, open and fair safety culture within the HPSS;
- Raising awareness of risk and promoting timely reporting of adverse incidents;
- Investigating serious incidents;
- Sharing the learning across HPSS environments;
- Implementing change;
- Developing skills, knowledge and expertise; and
- Involving and communicating with the public.

In support of the policy, an action plan has been developed, which places “Safety First” as the philosophy which all organisations, practitioners and staff should promote and adopt.

The action plan will be reviewed in 2007.

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SECTION 1 – AIM OF FRAMEWORK

1.1 INTRODUCTION

Safety has to be the first concern of everyone who works in or manages the Health and Personal Social Services (HPSS) in Northern Ireland. It is an integral part of quality in health and social care - diminished standards of safety reflect poor quality of service for people. Effective care, therefore, has to place an emphasis on efforts to improve safety processes in order to prevent adverse outcomes, and to improve the service user and carer experience. Safety is, therefore, an integral part of clinical and social care governance.

This document aims to draw together key themes to promote service user safety in the HPSS. It intends to build on existing systems and good practice, to bring about a clear and consistent DHSSPS policy and action plan, which can be reviewed in light of advances and developments. It does not aim to identify or replace existing policies and procedures, particularly those relating to statutory health and safety functions, or staff or visitor safety, but rather focuses on safety in terms of improvement of quality of care through enhanced clinical and social care governance.

The major policy focus and action will be on:

- creating an informed, open and fair safety culture across HPSS organisations;
- raising awareness of risk and promoting timely reporting of adverse incidents;
- sharing the learning across HPSS environments;
- implementing change;
- investigating serious incidents; and
- involving and communicating with the public.

Appendix A sets out the Terms of Reference and scope of this safety document. The action plan (section 5) will be reviewed in 2007, to determine progress and map future priorities.

1.2 ERROR – A PART OF THE HUMAN CONDITION

No health and social care environment is one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care. Many treatment decisions are made in a busy working day, using a range of technologies and

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activities (e.g. medicines, medical devices, equipment, procedures) and in different environments, which can, in themselves, be the subject of error. The factors which influence quality and safety of care, include:

- the context, e.g. HPSS, regulatory frameworks;
- the organisation and its management e.g. financial resources, priorities, policies, safety culture;
- the work environment e.g. staffing levels, skill mix, workload;
- the team e.g. structure, communication, supervision arrangements;
- the individual (staff) e.g. knowledge and skills, motivation, health;
- the task e.g. task design, use of protocols, accuracy of test results; and
- patient characteristics e.g. complexity of condition, language and communication, personality and social factors.[1]

Given the multiplicity of factors which influence the care of an individual, health and social services will never be totally error-free. But what can be achieved is the minimisation of risk, a greater knowledge and understanding of why human error and systems failures occur and the fostering of a culture which supports learning in order to prevent reoccurrence.

1.3 DEFINITION OF AN ERROR OR INCIDENT

It is important to have a common understanding of what constitutes an error or incident, regardless of the source. Errors can occur at all stages of the process of care, from diagnosis to treatment, to preventive care. Not all errors result in harm; these errors are often described as “near misses”. These too, represent an opportunity to identify systems improvements and have the potential to prevent adverse incidents in the future. All types of errors and incidents should be included in a common definition - social care, clinical, health and safety, fire, infection control etc., as they could potentially impact on the health and social care of service users, staff and visitors.

For the purposes of the Department and the HPSS, the regional definition of an error or incident is as follows:

[1] Adapted from; Vincent, Taylor-Adams and Stanhope 1998

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"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

The definition acts as a common working definition for HPSS organisations. It acknowledges that not all errors result in harm to patients and service users, but some do. Where the potential for harm/loss/damage is detected and the incident is prevented thus resulting in no harm to the individual, it is considered a "near miss" and can yield valuable learning.

The definition also supports the view that damage to property, environment or reputation can have both a direct and indirect impact and cost on health and social care. For example, faulty equipment may require tests to be repeated, potential for mis-diagnosis and concern for service users and staff. In addition, an incident may lead to loss of trust on behalf of the public and reduced satisfaction and morale among staff, with consequent negative impact on workforce recruitment and retention. More generally, employers and society may pay because of loss of worker productivity, school attendance, and a reduction in population health status. So, the human, social and economic costs resulting from adverse incidents are potentially high, but especially when a death occurs which may have been preventable.

1.4 THE HUMAN, SOCIAL AND ECONOMIC COSTS

The National Patient Safety Agency in England and Wales has produced its first report based on findings of the National Reporting and Learning System from November 2003 to March 2005. It shows a rate of five adverse incidents reported per 100 admissions in acute hospitals. In acute hospital settings, about three in every 1,000 reported incidents resulted in death[2].

Although many HSS Trusts and Boards have local incident reporting systems, the health and social services in Northern Ireland do not have a common reporting or data analysis system for adverse incidents; therefore, neither the number of adverse incidents in health and social care environments is known nor can the order of magnitude of untoward deaths be estimated. However, as with other developed healthcare systems, it can be reasonably assumed that the problem exists in our health and social care environment.

[2] Building a Memory: preventing harm, reducing risks and improving patient safety – The first report of the National Reporting and Learning System and the Patient Safety Observatory – July 2005 – www.npsa.nhs.uk

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What is known is the fact that any adverse incident, whether or not it results in injury, harm or death, has the potential to cause considerable distress not just to service users and carers but also to health and social care staff. For the families of those who have suffered the loss of a loved one, that loss can be made worse by the knowledge that death may have been preventable and that past lessons may not have been learnt.

The human, social and economic costs to individuals and families, the Health and Social Services and society are enormous. For example, in the HPSS:

- in 2004, via the Northern Ireland Adverse Incident Centre[3], 166 adverse incidents reports were received with 4 relating to circumstances involving fatalities;

- in 2004/05, a total of 10,107 medication-related patient safety incidents[4] were reported by staff in eight of Northern Ireland hospitals alone, although 89% of these were considered not to have caused harm (i.e. a near miss);

- in 2004/05, the frequency of MRSA[5] among hospital patients has shown a first and significant annual downturn during four years of monitoring, 242 patients were recorded as having MRSA in 2004/05 a decrease of 21% when compared to the same period in 2003/04;

- 15 suspected suicides and 3 suspected homicides occurred involving people in or who had just been discharged from mental health settings in the HPSS and were reported to the Department in 2004/05[6]; and

- in 2003/04, £15 million was paid in settlement of clinical negligence claims (HSS Boards and Trusts) with a future potential liability of around £100 million for current claims[7].

[3] Northern Ireland Adverse Incident Centre records and investigates, as appropriate, reported adverse incidents involving medical devices, non medical equipment, plant and building items used in the HPSS

[4] Source – Northern Ireland Medicines Governance Team

[5] Source - Communicable Disease Surveillance Centre – Northern Ireland – www.cdscni.org.uk

[6] Source – DHSSPS – Circular HSS (PPM) 06/2004. Reporting and follow-up of serious adverse incidents

[7] Source - DHSSPS

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1.5 LEADERSHIP AND ORGANISATIONAL CULTURE

The culture of an organisation is about "how we do things around here" and this is significantly influenced by the leadership of senior management. But for senior management to demonstrate leadership, it has to have the knowledge, skills and information to promote a safety culture.

An informed safety culture has four major sub-components[8]:

- *a reporting culture* - in which people are prepared to report their errors and near misses;
- *a just culture* – where an atmosphere of trust and fairness is created in which staff are encouraged to engage in safety related activities;
- *a flexible culture* - which respects the skills, abilities and limitations of frontline staff; and
- *a learning culture* – the willingness and competence to draw the appropriate conclusions from its safety information systems and to implement major reforms.

The DHSSPS endorses the approach that all organizations should have an informed safety culture, which should be given the highest priority at senior management level and promoted throughout as "everyone's business".

1.6 AN INFORMED SAFETY CULTURE

At present, there is no internationally accepted definition of patient safety incidents. Different definitions, information sources and methods of collection and analysis will affect findings. Appendix B provides examples of potential sources of information about the frequency of patient safety incidents and some of the strengths and weaknesses of each system. These include incident reporting systems, medical records review, surveys of patients and staff, and routine data collection. These illustrate the potential breadth of information sources, which contribute to knowledge of safety incident rates. However, for health and social care, the sources of reporting and data collection are even wider. What is needed is the systematic approach to data analysis and intelligence gathering from a range of sources, building on local, national and international capacity and capability, for example:

[8] Reason, J. Managing the risks of organisational accidents. Ashgate. Aldershot 1997

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- published literature for health and social care environments e.g. NICE, SCIE and NPSA;
- National Inquiries - e.g. Confidential Inquiries: CEMACH, NCISH, NCEPOD;
- statutory and voluntary reporting systems - e.g. local medicines and devices reporting, MHRA, child protection, Mental Health Commission;
- hospital and social care episode statistics;
- health and social care complaints;
- local and national Inquiries, e.g., Lewis, Ombudsman, Hyponatraemia, Climbié, Shipman and Bristol Inquiry Reports;
- regional and local audit findings;
- Regulation and Quality Improvement Authority (RQIA) reviews and reports;
- Social Services Inspectorate reports;
- claims and litigation findings;
- coroner's findings; and
- death certification data.

Building a comprehensive picture on safety as part of improved quality of care can be complex. However, given the relatively small population size in Northern Ireland and the integrated nature of health and social care services, this provides us with a unique opportunity to draw together the different strands of learning and disseminate it in a positive way - to improve quality of health and social care, rather than in a punitive way to blame and shame individuals or organisations.

Yet being a small region also has its disadvantages in that incidents may occur relatively infrequently here to make their detection and monitoring meaningful. We must also learn from errors detected nationally; we cannot "reinvent the wheel" in terms of national and international expertise and resources when trying to draw together all the variety of sources of information to enhance learning. So, a balance has to be struck between the need for local intelligence mechanisms and expertise, and building on national and international capacity and capability. Hence the need for links with national organisations such as the National Patient Safety Agency (NPSA), Social Care Institute For Excellence (SCIE) and the National Institute for health and Clinical Excellence (NICE) - to enhance both quality and safety in health and social care.

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KEY POINTS

- No health and social care service will ever be 100% error-free but what we can do is reduce the risk, enhance systems and expertise, and learn from adverse incidents and near misses.
- Strong leadership, a focus on systems and on organisational safety culture will reduce error.
- A regional definition of an adverse incident is identified covering health, social care, people, property, environment and reputation.
- A systematic approach to information gathering and data analysis is needed locally, which builds on national and international capacity and capability.
- No single source of information will provide all the data that is needed for safety analysis. For example, complaints, litigation, and death certification, together with adverse incidents reporting systems, audit and performance data need to be linked to enhance quality of care and be linked to evidence of effectiveness.

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SECTION 2 – CURRENT SYSTEMS TO PROMOTE SUSTAINABLE IMPROVEMENT IN THE HPSS

2.1 INTRODUCTION

Sustainable improvement is at the forefront of the development of health and social care services in Northern Ireland. This is being undertaken through a multi-faceted approach to modernising and reforming organisational structures and delivery of care, together with a greater emphasis on quality, safety and accountability for the commissioning and delivery of that care.

Although healthcare systems from around the world vary considerably, many developed countries, such as the United States of America, Australia and the United Kingdom are leaders in the field of patient safety initiatives. Last year the UK European Union Presidency had a major focus on patient safety.

This section of the Safety Framework recognises that quality and safety are part of the continuum of local service improvement and are integral to good governance of an organisation. It sets out:

- the local commitment to quality and service improvement;
- safety and risk management systems underpinning good governance;
- local examples of organisational cultural change;
- links to national standard-setting bodies;
- examples of learning from local serious adverse incidents;
- changes to HPSS complaints procedures;
- serious adverse incident interim reporting arrangements; and
- the need for education, workforce development and regulation.

2.2 A COMMITMENT TO QUALITY AND SERVICE IMPROVEMENT

In 2001 the Northern Ireland Executive gave a commitment in the first Programme for Government to put in place a framework for raising the quality of services delivered and for tackling poor performance in the HPSS. Since then, much work has been undertaken to bring forward this programme.

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The consultation document "Best Practice – Best Care"[9], issued in April 2001, was the first step towards fulfilling this commitment. It set out proposals to put in place a framework to raise the quality of services provided to the community and tackle issues of poor performance across the HPSS. The aim was to provide a high quality system of health and social care, which was easy and convenient to use, was responsive to people's needs and provided a service that instilled confidence in those who used it.

The quality improvements in "Best Practice – Best Care" are centred on five main areas:

- setting of standards: to improve services and practice;
- improving governance in the HPSS: in other words, the way in which organisations manage their business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they commission and/or provide: the Duty of Quality; and
- establishing a new, independent body to assess the quality of health and social care - the Regulation and Quality Improvement Authority (RQIA).

From 1 April 2003, a statutory duty of quality was placed on HSS Boards and Trusts. Under this duty, each Board/Trust is required to[10] "*put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them*". This requirement to deliver on the quality of services is similar to the requirements already placed on the HPSS to ensure financial probity.

RQIA came into operation from April 2005. RQIA's principal role includes the registration, regulation and inspection of a wide range of services delivered by the independent sector and the HPSS, and to report to the Department on the quality of care provided by the HPSS. In addition, it has a general role to promote and facilitate quality improvement in health and social care.

[9] Best Practice – Best Care: a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS

[10] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (S.I. 2003 No.431 (N.I.9))

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In order to provide greater consistency and accountability in the quality of care provided, and to facilitate the RQIA in its role, a range of standards have been developed, including:

- controls assurance standards[11], to assist HPSS organisations to demonstrate that they are doing their reasonable best to manage risk effectively;
- minimum care standards[12], applicable to agencies and establishments in the independent, voluntary and statutory sectors and to certain HPSS services; and
- generic quality standards[13], applicable to primary, secondary and tertiary care in the HPSS.

The above developments all contribute to good governance within the HPSS.

2.3 SAFETY AND RISK MANAGEMENT AS PART OF GOOD GOVERNANCE

All HPSS organisations are required to have a system of internal control to help facilitate the flow of information about risk both up and down and across the organisation. Part of this system is the recording of risks on risk registers. These are held at key points within the organisation depending on its size and structure. When most effective, a system of risk management involves every member of staff, and the organisation as a whole being aware of the key risks that affect them.

The function of risk registers is to inform key decision-makers of the risks they need to know about in order to fulfill their role in the commissioning and delivery of care. The recently-produced "Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations[14]" is written to help HPSS board members, directors and senior managers within the HPSS to further improve their systems of internal control and to embed the principles of whole-organisation risk management as an integral part of quality health and social care. It acknowledges

[11] Controls assurance standards available on: http://www.dhsspsni.gov.uk/index/health_and_social_services/governance/governance-controls.htm
[12] Draft care standards available on: http://www.dhsspsni.gov.uk/index/consultations/previous_consultations.htm
[13] The Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS available on: http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf
[14] Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations – http://www.dhsspsni.gov.uk/publications/2006/assurance_framework.pdf

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that decisions by individuals, managers and directors can positively or negatively affect the delivery of care to the individual.

Knowledge and skills in the assessment and appropriate management of risk in an often rapidly changing environment of care are essential to organisational health, to ensure safety and to improve outcomes in clinical and social care. Clear roles, policies, procedures and systems will help facilitate appropriate risk decisions and minimise inappropriate and potentially damaging decisions. This includes a system for assuring that each organisation has available information about key elements of risk:

- at the right time;
- in the right way; and
- to the right person(s).

This enables the most appropriate decisions to be made and facilitates the promotion and delivery of improvements in care.

2.4 SUPPORTING CULTURAL CHANGE

Having appropriate procedures to identify, assess and manage risk is central to organisational health, but this has to be complemented by cultural change in order to demonstrate a commitment to good practice, drive quality and enhance organisational performance. The following four initiatives are all examples which support cultural change:

The Clinical and Social Care Governance Support Team (CSCG) was established by the DHSSPS in 2004. In establishing the CSCG Support Team, the Department's aim was to promote the longer-term cultural change and organisational development that it considered necessary to ensure that the statutory duty of quality could be implemented successfully and consistently in the HPSS. In turn, this would lead to a continuous improvement in health and social care services in Northern Ireland. A decision to link with the NHS Clinical Governance Support Team in developing these local arrangements was taken on the basis that the HPSS would have access to the experience, knowledge and tools already developed in the NHS. The CSCG Team has developed an extensive work programme across primary, community and secondary care. This programme has included specific training initiatives and topic specific programmes, such as in elderly care, to facilitate a multidisciplinary approach to learning and to champion

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quality improvement. It complements the many other local initiatives, some of which have been ongoing for a number of years, such as the Clinical Resource Efficiency Support Team (CREST) which aims to drive up standards in clinical practice by the production of specific guidance.

Regional Governance and Risk Management Adviser - The post of Regional Governance and Risk Management Adviser, sponsored by the Department from October 2003, was initially focused on supporting the HPSS in embedding the fundamental structures and processes of risk management. The post promotes a joined-up approach to governance arrangements in HPSS organisations. Integral to this is the involvement of the adviser in a range of safety, quality and risk management initiatives. A major project is underway relating to the standardisation of definitions and coding to enhance incident management (see Appendix D).

The Northern Ireland Medicines Governance Team aims to improve medication-related patient safety by a systematic regional approach to medication risk management through the deployment of six senior pharmacists dedicated to medicines risk management in Northern Ireland hospitals. Beginning in August 2002, the team has addressed three main areas: the development of the risk management process itself, including identification, analysis and evaluation of risk, the development of 'good practice' initiatives and risk education. In November 2004, the Team was awarded the Health Service Journal Award for Patient Safety. As part of the Pharmaceutical Services Improvement Projects currently underway, funding has been secured to extend the Medicines Governance Team, with the aim of enhancing medicines governance arrangements in the primary care sector of the HPSS.

The Safer Patient Initiative, promoted and funded by The Health Foundation Trust, in collaboration with the Institute for Healthcare Improvement (IHI) in the USA, aims at making hospitals safer for patients in the UK. Following rigorous assessment of applications, Down Lisburn Trust was one of four UK Trusts selected to start work on the safety initiative in October 2004. This provides the Trust with an opportunity to work with an expert team from IHI and world experts to promote safety and quality. The four UK Trusts were selected for this prestigious project on the basis of their exceptionally high level of commitment to improving patient

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safety. The project will last for two years; the selected trusts are expected to become exemplars in patient safety so that other hospitals can learn from their success.

2.5 LINKING WITH NATIONAL BEST PRACTICE

Whilst HSS Boards and Trusts in Northern Ireland have the capacity to be leaders in the field of quality and safety, given our relatively small size and limited resources, we must draw on the wide range of skills, knowledge and expertise that is available at national and international level. The establishment of appropriate links with national best practice and standard setting bodies is a key element in the framework for raising the quality of health and social services in Northern Ireland. These links are necessary to secure access to independent evidence-based guidance to promote safe, effective and efficient care.

It is recognised that guidance developed in Great Britain should generally have universal application and that local duplication is unnecessary.

Current progress on the Department's links with national bodies is outlined below.

- **National Patients Safety Agency (NPSA)** - A formal agreement with NPSA to extend its services to Northern Ireland is planned from April 2006. This will provide access to the whole range of NPSA's training material, tools and guidance to promote and facilitate safety in the HPSS. This will include access to the NPSA's *Seven Steps to Safety* programme for both primary and secondary care, adapted to meet the need of our integrated health and social care environment. In addition, the HPSS will eventually join with the National Reporting and Learning System, to facilitate an integrated approach to reporting and learning from adverse events (see section 3). The NPSA's Patient Safety Observatory will bring together many sources of information and facilitate benchmarking on safety across the HPSS with other regions.

- **National Clinical Assessment Service (now part of NPSA but previously the autonomous National Clinical Assessment Authority)** - Since October 2004, NCAS provides advice, support, and assessment for HPSS organisations where a doctor's or dentist's performance is called into question (see section 3). This was one of the key

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recommendations in *Confidence in the Future for Patients, and for Doctors*[15]. This document set out proposals for the prevention, recognition and management of poor performance of doctors.

- **Social Care Institute for Excellence (SCIE)** – SCIE was developed to identify and promote dissemination of knowledge about what works in social care. A service level agreement was established with SCIE in June 2004 extending the Institute's remit to cover Northern Ireland. Local social care practitioners and academics are now actively involved in SCIE projects and the development of best practice guidelines.

- **National Institute for health and Clinical Excellence (NICE)** - Whilst NICE guidance has no formal status in Northern Ireland, many parts of the HPSS draw on the material produced by the Institute. The Department has had negotiations with NICE on formal links and is represented, in observer capacity, on the committee that provides advice on the selection of topics for NICE appraisal and guidance programmes. A process for reviewing the applicability of NICE guidance to Northern Ireland and, where appropriate, endorsing it for uptake in the HPSS is being put in place. In addition, the HPSS will link with NICE new interventional procedures programme to ensure that new procedures used for diagnosis and treatment are safe enough and work well enough for routine use in the HPSS.

2.6 LEARNING FROM LOCAL ADVERSE INCIDENTS

The provision of health and social care will never be error free due to the complexity of factors which contribute to that care. It is acknowledged that the majority of errors do not lead to any harm for patients, staff or service users, but unfortunately some will. Recent examples of adverse incidents which continue to receive much attention, because of potential severity of outcome are:

- **The Independent Review of Endoscope Decontamination,** was established in June 2004, following concerns about the effectiveness of decontamination of endoscopes in some locations in Northern Ireland. This was chaired by Dame Deirdre Hine. It examined the systems and processes in Trusts to ensure the effective cleaning and

[15] www.dhsspsni.gov.uk/publications/archived/2000/confuture.pdf

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high-level disinfection of flexible endoscopes before and after their use on patients, and found a number of areas in which procedures could be improved. Implementation of the recommendations is currently underway.

- **Inquiry into Hyponatraemia – Related Deaths[16].** In November 2004, the Department appointed Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of three young children, with particular reference to their care and treatment in relation to fluid balance, and the role that individuals and organisations played following their deaths.

- **The Management of Hyperkalaemia in Adults.** Following recent serious adverse incidents relating to blood electrolyte abnormalities involving potassium, the Clinical Resource Efficiency Support Team (CREST) produced guidelines and wall charts for every local organisation to provide clear and concise information to enable clinicians to safely and effectively manage patients presenting with hyperkalaemia.

- **Post operative care following laparoscopic abdominal surgery.** An independent review team produced a report on lessons arising from the death of Mrs Janine Murtagh. It contained a number of recommendations covering consent, patient care, leadership and communication, and the implementation of policies and procedures.

2.7 ARRANGEMENTS FOR MONITORING AND LEARNING FROM SERIOUS ADVERSE INCIDENTS

In July 2004, interim guidance was issued to the HPSS, including family practitioner services, on the circumstances where particular serious adverse incidents or near misses must be reported to the DHSSPS (Circular HSS (PPM) 06/04). These are where the episode is considered:

- to be serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff;
- to be of such seriousness that it is likely to be of public concern; or
- to require independent review.

[16] www.ihrdni.org

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The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating to, for example, medical devices, equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the DHSSPS.

The new interim reporting arrangements on serious adverse incidents (SAI) were developed to try and ensure that lessons are learned across the HPSS and that serious local incidents are not repeated. The DHSSPS plans to collate learning from reported SAIs and produce an annual report. DHSSPS will also hold SAI briefings for the HPSS at regular intervals. HPSS directors and senior officers responsible for safety and quality will attend these meetings in order to gain information on the emerging current picture of SAIs across the HPSS. This will present an opportunity for the service to share learning and discuss possible improvements to the current reporting mechanisms in order to facilitate further sharing and learning.

It is recognised that different sources and types of data on adverse incidents all contribute to our knowledge of adverse incidents. Examples include “near misses”, complaints, social care inspections, litigation, audit, records review, confidential inquiries etc., together with information about relatively infrequent incidents, which occurred in other health and social care systems. Through the NPSA’s National Learning and Reporting System, and Patient Safety Observatory, the triangulation of data sources and analysis will be facilitated. However, there will remain a need to have some local reporting arrangements to ensure timely dissemination of local adverse incidents and near misses. Work will be done to clarify arrangements and avoid duplication.

2.8 EDUCATION, WORKFORCE DEVELOPMENT AND REGULATION

Staff and HPSS organisations must be able to justify the trust that the public places in them. For this to happen, the DHSSPS and the HPSS need to be able to demonstrate that good standards of practice and care are being maintained and that respect for service users is being shown. It is recognised that when safety and quality are introduced early into educational programmes, this has a positive impact on the future delivery of safe and effective care. Consequently, the content of this framework will be of use to educational providers.

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The maintenance of good standards of practice and care requires individuals and organisations to have a learning culture, and one which supports training and development of staff. Training and development needs analyses, linked to regional, local, organisational and individuals' priorities and objectives, are essential for the ongoing enhancement of quality and safety within the HPSS. The introduction of quality assured appraisal systems which facilitate review of performance and the identification of development needs have the capacity to improve treatment and care and reduce error.

The regulation of the workforce has a major part to play in the promotion of quality and safety. Regulation and responsibility should take place at different levels[17], for example:

> **Personal level** – based on a commitment to quality of care that puts the safety and care of the patient and service user first;
>
> **Team level –** based on the concept of the importance of team working and the requirement to take responsibility for the performance of the team, and to act if an individual's conduct, performance or health is placing the public at risk;
>
> **Workplace level** – which reflects the responsibility that HPSS organisations have for ensuring that staff, equipment and facilities are fit for purpose in the commissioning and provision of care. This is expressed through the Duty of Quality, clinical and social care governance, performance management systems and compliance with legislation; and
>
> **Professional level –** which is undertaken by statutory regulators, for example, working through the development of standards, education, registration and licensing, and fitness to practise procedures.

Examples of professional regulators include the General Medical Council, General Dental Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, the Health Professions Council, General Optical Council and the Northern Ireland Social Care Council. All of these organisations have a major part to play in the promotion of quality of care and in the identification and management of fitness to practise. The Council for Healthcare Regulatory Excellence was formed in April 2003 to

[17] Adapted from Developing Medical Regulation: A Vision for the Future – April 2005 - GMC

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ensure consistency of approach and good practice among nine "health" regulators. Several of the professional regulatory organisations identified above are undergoing development and change. Many of the drivers for change in the regulation of the workforce are as a consequence of national inquiries such as, the Bristol, Shipman, and Climbié Inquiry Reports.

Locally, a number of organisations also promote best practice and enhanced clinical and social care performance, including:

Northern Ireland Social Care Council (NISCC) – As part of the Northern Ireland Assembly's commitment to raising the status of the whole social care workforce, raising the standards of social care practice and ensuring proper protection of the public against persons who are unsuitable to carry out the work, NISCC was established in 2001 to regulate the social care workforce and to regulate the training of social workers.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) – In 2002, NIPEC was established to shape practice, education and performance within the professions of nursing and midwifery in Northern Ireland and to equip nurses and midwives in such a way as to enable them to provide better care for patients and service users.

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KEY POINTS

- Sustainable improvement in health and social care requires a multifaceted approach, including service reorganisations and reform, and an emphasis on safety and quality as part of good governance.
- Systems and procedures for the identification, assessment and management of risk are important but have to be supported by organisational cultural change to promote sustainable quality improvements.
- Much work had already been undertaken locally to support quality and safety.
- National links are an important way of gaining access to knowledge, skills and best practice.
- Linkage with the National Patient Safety Agency, National Institute for health and Clinical Excellence, and the Social Care Institute for Excellence are pivotal to the promotion of quality and safety.
- Education, workforce development and regulation occur at individual, team, organisational, regional, and national levels; it is part of the drive to promote quality and protect the public.
- Recent local adverse incidents emphasise the need to put *safety first.*

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SECTION 3 – PROMOTING SERVICE USER AND STAFF SAFETY

3.1 INTRODUCTION

Section 2 identified the progress that has been made to date to promote and embed quality and safety within HPSS environments. This section builds on this work and identifies other key elements to promote service user and staff safety. These include:

- creating an informed, open and fair safety culture across the HPSS;
- raising awareness of risk and promoting timely open reporting of adverse incidents;
- sharing the learning across HPSS environments and implementing solutions; and
- investigating serious incidents.

To facilitate implementation of these key elements requires co-ordinated action involving individuals, the HPSS including family practitioner services and the DHSSPS. Actions to promote and support a safer service are identified in section 5. This section is written for managers, educationalists and practitioners to clearly document high level work which needs to occur between 2006 and 2007. The action plan is outcome focused and attributes responsibilities.

3.2 CREATING AN INFORMED, OPEN AND FAIR SAFETY CULTURE ACROSS ORGANISATIONS

An informed organisational culture that promotes safety and quality should be at the centre of every stage of prevention, treatment and care. Section 1 identified four main components of an informed safety culture as:

- a reporting culture;
- a just culture;
- a flexible culture; and
- a learning culture.

A just culture is one that is seen to be open and fair to staff. Creating such a culture encourages the reporting of incidents, which is essential to the success of data collection and subsequent improvement in activity, systems, and care.

An “open and fair” organisation can be defined as a one where staff are not blamed, criticised or disciplined as a result of a

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genuine slip or mistake that might have lead to an incident. Disciplinary action would, however, follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm. In determining 'blameworthiness', a 'fair' approach is one that separates the actions of individuals involved from the patient outcomes. A 'fair' culture advocates the systems approach, recognising that accidents may occur as a result of a series of system failures rather than through a deliberate malicious act on the part of an individual. Moving to the systems approach will be an important challenge. Research has shown that currently 85% of health care incidents are caused by systems failures yet, 98% of remedial action focuses on the person or people involved in the incident[18].

Organisations that operate a 'fair' culture are more likely to gather useful information about their organisation that can be used to further improve safe practice and pre-empt future incidents. In this way the organisation can acknowledge mistakes, learn from them and take action to put things right. This is an integral part of what the public wants the HPSS to achieve.

But being "open and fair" also means that the organisation should encourage staff to be open and fair when communicating with patients, service users and carers. This is a part of the redress that people can and should expect when things go wrong and where harm has been caused. This includes an organisational commitment to providing an explanation of what happened, an apology, a reassurance of speedy remedial treatment and, where appropriate, financial compensation.

Any change in culture requires sustained commitment at the most senior level in the organisation. Frank and open discussion needs to occur within senior management and agreement reached on what an open and fair culture will mean in practice for their organisation and this needs to be cascaded throughout the organisation as part of an overarching policy on safety. There are many tools which can assist HPSS organisations in assessing organisational safety culture in terms of underlying beliefs, attitudes and behaviours. In addition, tools such as root cause analysis and NPSA's Incident Decision Tree can assist in distinguishing between poor performance of the individual and a systems failure.

[18] Overveit J. Health Service Quality. Brunel University, 1998

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3.3 RAISING AWARENESS OF RISK AND PROMOTING TIMELY REPORTING

Raising awareness of risk implies that all members of an organisation should have a good understanding of the factors that contribute to human and organisational error. In addition, there is a need for individuals to recognise that no-one is perfect; that there is always the capacity to reflect on one's work and to improve. Key tools to enhance this reflection are, for example, professional appraisal, audit and significant event analysis, and multidisciplinary team discussion and analysis.

Raising awareness of risk has to happen at all levels within an organisation. Whilst much work has been done to promote risk assessment and risk management within HPSS organisations within recent years, there remain opportunities which the HPSS will have, in the near future, including access to all NPSA material, tools and guidance.

Recent HPSS adverse incidents, highlighted through the coroner's service, have emphasised the need to pay particular attention to risk awareness and action within undergraduate and post graduate training programmes, newly appointed staff and at vulnerable interfaces such as the transfer of patients to different parts of the HPSS or at the interface between secondary, community and primary care. Specific action to raise awareness in these vulnerable areas needs to be undertaken. In particular, risk awareness should be incorporated into education and training programmes; there should be mandatory training for all newly recruited staff on basic organisational risk awareness, policies and procedures, risk within their specific areas of work, and on incident reporting systems. This should be seen by senior management as an integral part of a new recruit's induction into the organisation. In addition, all existing staff should have in-service education and training to support the continual awareness of risk. Appendix C provides an example of a training programme to promote risk awareness.

It must be explicit in all training and incident reporting and management policies that a staff member's responsibility for patient and service user safety comes before any responsibility to other staff, for example, in their own team or profession. This is supported by the codes of conduct for each profession and must be observed regardless of the severity of the incident(s) concerned.

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Promoting a reporting culture is an important challenge for all sections of the HPSS and one which is essential if organisations and individuals are to learn from errors. Timely and open reporting is part of individual and organisational responsibility to quality improvement and learning. Whilst it is acknowledged that the majority of incidents do not lead to harm, valuable lessons can be learnt from these and "near misses" – where an error was detected and stopped before it resulted in harm. Research has shown that the more incidents and near misses that are reported then the more information there is about what is going wrong and the more action that can be taken to make health and social care safer both locally and nationally[19].

It is essential that commitment from senior management within the organisation is evident and that clear lines of accountability and communication are defined. It is equally important to ensure that policies and procedures are not simply 'for show' and that staff experiences reflect the ethos agreed by senior management. For example, the ways in which the reporting, investigation and subsequent management of medication incidents have been handled to date, indicates that cultural change is possible and, as a consequence, staff are willing to report incidents. But for staff, the benefits of reporting are not always made clear, particularly when there is a fear of blame, no noticeable change and no feedback. In addition, reporting can seem time-consuming and complicated.

The benefits of reporting need to be cascaded throughout the HPSS. These include:

- improvement in care of patients, clients, service users and staff;
- resources targeted more effectively;
- increased responsiveness;
- pre-empting complaints; and
- reducing costs.

3.4 REGIONAL REPORTING SYSTEMS PROJECT

In order to promote consistency of approach to reporting, in January 2005, the DHSSPS commissioned a project to be carried out across the HPSS to standardise definitions, reporting forms and the coding of incidents. A summary of the first phase of this project is included in Appendix D. This work should help facilitate

[19] Seven Steps to Patient Safety – NPSA - 2004

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the sharing of learning between HPSS organisations as data can be shared and analysed more easily across Trusts, Boards and relevant Agencies that comprise Northern Ireland's HPSS. This project's remit encompasses all adverse incidents, inclusive of clinical incidents, social care, staff incidents and any other adverse event that may affect the operation of the HPSS, including the family practitioner services. The work will further facilitate a future link with the National Patient Safety Agency's National Reporting and Learning System.

Whilst local reporting mechanisms will always be important, there is some potential duplication in current reporting systems at local, regional and national level. This is because reporting systems serve different purposes and may have different specialist audiences. In order to provide a greater understanding of where the links are at local, regional and national level will require the Department to work with the HPSS and the NPSA to promote a consistent approach. Of particular importance is the incorporation of all health (both clinical and non clinical) and social care incidents.

The Regional Reporting Systems Project is part of the work to provide greater consistency of approach locally. This Project is part of the phased implementation plan to join with the NPSA's National Reporting and Learning System (NRLS). Joining the NRLS will mean that the HPSS will receive comprehensive reports on patient safety incidents, tailored to the needs of Northern Ireland, but it will also facilitate comparisons with other regions in England and Wales on the frequency of reporting and type of incident. In addition, through the Patient Safety Observatory, the Department and HPSS will have access to the learning that will emerge from other reporting systems and sources, such as, MHRA for medicines and medical devices, professional bodies and National Confidential Enquiries. Use of computerised data analysis tools will help identify potential clusters, patterns and trends across these reporting systems.

Comparisons between regions are important; however, there remains a need within each HPSS organisation to ensure that a reporting culture is fostered and that tools such as the Heinrich ratio are used to regularly assess the "health" of the organisation's reporting system and, where appropriate, ask area/sections which are not reporting for a "nil return" to confirm that incidents have not occurred.

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3.5 SHARING THE LESSONS ACROSS THE HPSS

Section 1 provided examples of the many and varied data sources from which learning on safety and quality issues can occur - for example, audits reports, incidents reporting systems, complaints procedures and claims and litigation. When an incident occurs, a fundamental principle of a systems approach to error management is the understanding of how and why an incident occurred[19]. It is only then that learning can be shared and the lessons learnt used to prevent its reoccurrence. The sharing of learning can and should take place at different levels, for example:

- multidisciplinary team discussion within HPSS organisations;
- participation in personal and team education, training and development e.g. development of guidelines and solutions;
- training and participation in and use of investigative tools such as Root Cause Analysis;
- formal data collection and analysis procedures e.g. outcome statistics discussed at team, clinical and social care governance and senior management levels;
- formal communications pathways and networks e.g. urgent communications, newsletters, IT-based systems and discussion fora; and
- production and cascade of annual/ quarterly reports on adverse events.

Further consideration will be given to developing a single information gateway to bring together all departmental publications and guidance in an accessible format and on a monthly basis. In addition, the DHSSPS and the HPSS will consider how the extranet could be used to disseminate the results of all root cause analysis between organisations.

The accountability for patient, service user and staff safety rests with the Chief Executive of an organisation. To facilitate discussion, analysis and feedback, an integrated governance approach should be encouraged within HPSS organisations. There is a need to ensure that there are clearly delineated relationships and communication pathways within the organisation. This is necessary so that front line staff and, in particular, clinical and social care governance leads and risk managers have access to up to date information and that there is a feedback loop to ensure that safety information is received and acted upon within an appropriate timeframe.

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The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health in England, with the MHRA, NHS Estates and the NPSA. The aim of this system is to bring different types of alerts together into one electronic system thus ensuring that all urgent communications are received and implemented. Nominated leads in each Trust and Primary Care Trust are asked to disseminate it to those who need to take action. This role is similar to the current MHRA medical device liaison officer role but with the additional responsibility of providing feedback on action to implement the alert using a simple electronic form. The development of a Service Level Agreement with NPSA will provide an opportunity for the Department to explore with the Department of Health in England if appropriate links to the SABS system can be established.

3.6 INVESTIGATING SERIOUS INCIDENTS

Obtaining incident reporting data is just the first step towards a comprehensive approach to safety. Significant investment has been made locally and nationally in root cause analysis training to promote proper understanding of the cause(s) of an adverse incident. There should be a consistent approach to deciding which incidents need to be followed up and further investigated; these should follow best practice in the use of tools for root cause analysis. There are two main criteria, which the HPSS should use in determining further investigation of an incident:

- ***the level of severity/grade of the incident*** - e.g. an untoward death or permanent injury; and
- ***the potential for learning*** e.g. frequency of incident or near miss.

The Chief Executive of the organisation is responsible for investigating the cause of a serious incident as part of his/her commitment to quality of care, which is underpinned by the Duty of Quality. The immediate priority in this case should be to take all the necessary steps to secure the safety of services users, staff and other people involved. All HPSS organisations should have clear policies on incident reporting including a standard approach to investigation of each level of severity of incident. This will be facilitated by the Regional Reporting Systems Project (see Appendix D) and links with the NPSA.

Incidents involving unexpected death or serious harm and requiring investigation by the police and/or the Health & Safety Executive (HSENI) are rare but have increased in number in the

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past few years. There is a statutory duty placed on individuals and organisations to report such incidents. When they happen, incidents need to be handled correctly for public safety reasons as well as the maintenance of confidence in the HPSS, Police, Coroner and Health and Safety Executive. To achieve this, it is important that these four arms of the public sector communicate and work with one another in a consistent and ordered manner. The DHSSPS has finalised a Memorandum of Understanding[20] between these four organisations in order to better facilitate these complex interactions. The Memorandum complements existing joint procedures in relation to the protection of children and vulnerable adults.

Special action must be taken in the event of a public health hazard such as a major incident, chemical contamination, or biological, radiological or nuclear emergency. Specific regional guidance governs arrangements for dealing with major incidents.

Regional guidance should be followed where incidents involve suicides or other serious events involving people who have a mental disorder, child protection issues or when an incident fitting the criteria of a National Confidential Enquiry has occurred.

Where an incident involving a medicine has occurred, which falls within the remit of the Medicines Act and the Pharmacy Inspectorate of the DHSSPS, organisations should comply with regional reporting arrangements and co-operate with the investigation.

3.7 ENHANCED ASSESSMENT OF CLINICAL AND SOCIAL CARE PRACTICE

In countries that have promoted safety and quality in healthcare, there is a link between institutional assessment, reviews, accreditation and safety and quality initiatives; the assumption being that quality and safety, to some extent, can be assured by a review, inspection or an accreditation process. All of these processes take account of recognised standards of care.

This inspection, review or accreditation can take place at different levels, for example at:

- national level – through professional bodies and national accreditation schemes;

[20] http://www.dhsspsni.gov.uk/mou_investigating_patient_or_client_safety_incidents.pdf

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- regional level – though statutory inspection procedures and clinical and social care governance reviews;
- local level – through commissioning arrangements with providers of care; and
- individual level – through the organisational assessment of individual performance.

The RQIA will be reviewing clinical and social care governance within the HPSS using the five themes contained within the Quality Standards, with particular emphasis on Safe and Effective Care. This approach will assist RQIA and the HPSS in the future development of methodologies and the refinement of self-assessment processes.

RQIA will report on the quality of care provided by the HPSS following its governance reviews. This developmental approach will promote quality improvement across organisations.

In addition to RQIA's inspection and review functions, it also has the power to investigate serious incidents at the request of the Minister, Department or the public. It will report to the Department on the quality of care within all HPSS services. As the work of RQIA progresses, it will provide a rich source of learning for the HPSS, the DHSSPS and the public.

At national level, the impact of major inquiries such as Shipman, Kerr/Haslam and Climbié, will continue to have a major impact on organisational and professional practice locally. In addition, reviews[21], such as those currently being undertaken by Sir Liam Donaldson and Mr Andrew Foster will impact on clinical and social care governance arrangements locally, including how an individual practitioner's fitness to practise is assessed.

A formal link with the National Clinical Assessment Service has already been established to provide advice, support and, where appropriate, full assessment for HPSS organisations, where a doctor's or dentist's performance is called into question. In addition, annual appraisal of individuals is now a reality for many HPSS staff. Where performance of an individual is considered to put patients or service users at risk, then the organisation must have processes in place to facilitate action and prevent harm.

[21] CMO Review of Medical Revalidation: A Call for Ideas, 3 March 2005 – www.dh.gov.uk; Review of Non-Medical Regulation – Call for Ideas, 29 June 2005, Mr Andrew Foster – www.dh.gov.uk

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New disciplinary procedures for HPSS-employed doctors and dentists have been introduced to promote the early and active assessment and resolution of concerns regarding clinical practice. In addition, primary legislation is being drafted for the family practitioners services, to further extend the function of the Health Service Tribunal and the powers of HSS Boards where there is a concern about professional or personal conduct or practice.

A local response to Shipman Inquiry recommendations will be produced, to cover:

- Shipman 3 – Recommendations on new death certification pathways and investigation;
- Shipman 4 – Recommendations on enhanced monitoring and inspection of controlled drugs; and
- Shipman 5 – Recommendations on complaints, whistle-blowing, appraisal and professional performance.

3.8 DESIGNING AND IMPLEMENTING SOLUTIONS

The HPSS does not, as yet, have good mechanisms to facilitate the sharing of solutions on quality and safety problems. There is often excellent work in progress across the HPSS but no clear forum for sharing this work to others in similar situations. This may lead to duplication and wasted resources and the reoccurrence of adverse incidents. The measures identified in paragraph 3.4 will facilitate the cascade of effective solutions. So too will links with national bodies specifically involved with solutions development such as the NPSA, MHRA and the NHS Purchasing and Supply Agency.

Whilst reporting systems are a pivotal part of the identification of trends and themes requiring solutions, they are not the only source of information at local or national level. There is a need, therefore, to promote partnership working within the HPSS and at national level to share resources in solutions development. However, where a solution needs to be developed and implemented locally, it should be specifically commissioned by the DHSSPS with the scope of the project clearly defined and resourced.

To facilitate implementation, where appropriate, a solution should be designed in toolkit format in order to promote consistency of approach across the HPSS. As identified in the Safety Alert Broadcast System (SABS), there should be a feedback loop to confirm that implementation is completed. New arrangements for regional audit should be linked to the wider quality and safety

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agenda and used to facilitate implementation of solutions, where appropriate.

The development of a Service Level Agreement with the NPSA opens up the possibility for the HPSS to be selected to pilot new approaches to the delivery of care/improvements in patient safety. This is particularly appropriate in areas where the HPSS has carried out innovative work e.g. Medicines Governance and in areas where the HPSS presents a unique challenge, for example, the large and complex area of social care. Participation in the development of innovative work will stimulate the further development of a safety culture across the HPSS and will engage both health and social care professionals.

Effective design of health and social care facilities remains an important aspect of quality of care. This is because effective design thinking can deliver products, services, processes and environments that are simple to understand, to use, comfortable and convenient, and consequently less likely to lead to accidental misuse, error and accidents. The report, *Design for Patient Safety* [22] identifies opportunities for improving patient and service user safety through the more effective use of design.

[22] Design for patient safety: A system-wide design-led approach to tackling patient safety in the NHS Department of Health and the Design Council. February 2004. Available at : http://www-edc.eng.cam.ac.uk/medical/reports.html

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KEY POINTS

- An **informed** organisational culture, that builds on many data sources, is necessary to promote safety and quality. This culture requires endorsement and agreement by senior management in order to promote a **reporting** culture, and one, which is seen to be **just**, **flexible** and has the capacity to **learn** from errors.
- A systematic approach to raising awareness of risk of the factors that contribute to human and organisational failures is essential for staff, especially new recruits.
- Promoting timely open reporting is a major challenge for all HPSS organisations; the benefits of reporting should be highlighted to staff with clear feedback mechanisms identified.
- The first step to a comprehensive approach to safety, is obtaining and analysing **all** incident data. Clear policies and procedures for the reporting and investigation of serious incidents are the responsibility of senior management.
- The NPSA's National Reporting and Learning System will facilitate a cohesive approach to data collection in Northern Ireland and will facilitate benchmarking against other regions.
- Links to the NPSA, through its "Seven Steps" Programme together with use of tools and guidance will promote reporting and investigation of serious incidents in secondary and primary care, and build on existing work.
- Designing and sharing the solution, should draw on national and local work; where appropriate, local organisations should lead in the piloting of such solutions.
- Enhanced assessment of clinical and social care practice through HPSS Regulation and Quality Improvement Authority will promote learning.
- Where individual performance is called into question, the National Clinical Assessment Service will provide advice and support to organisations, and formal assessment of the individual, if required.

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SECTION 4 – INVOLVING AND COMMUNICATING WITH THE PUBLIC

4.1 INTRODUCTION

There is now good evidence that trusting and respecting the patient/user at a number of levels (e.g. individual and community) in the health and social care system improves health and well-being significantly[23]. Patients, service users and the public have a major part to play in the prevention and detection of errors in health and social care.

4.2 PUBLIC INVOLVEMENT IN PROMOTING HEALTH, WELL-BEING AND SAFETY

People are ultimately responsible for their own health and well-being, and that of their dependants. However, it is acknowledged that health and well-being are influenced by many factors, such as poverty, crime, violence, education and unemployment. HPSS service provision plays but one part in the overall health of the population. The HPSS needs to work in partnership with other agencies, communities and the media to seek to influence and improve the health, social well-being and safety of the public and their staff. In this regard the media have an important public health and safety role in tandem with their duty to responsibly hold public bodies to account.

The Quality Standards for Health and Social Care set out the values and principles which all HPSS organisations and staff should adopt when engaging with the public and service users. These include the need to involve people in all stages of care and to provide timely and appropriate information to assist in decision-making.

Integration of service users, carers and local communities into all stages of planning, development, evaluation and review of health and social care services is an important part of continuous quality improvement and the open culture which should be promoted throughout the HPSS.

Through proactive involvement of the public in safety matters, it is hoped that:

[23] www.pickereurope.org

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- risks will be identified;
- concerns and ideas for improvement will be shared; and
- solutions will be generated in partnership with service users and the public which will be more realistic and achievable.

4.3 PUBLIC EXPECTATION OF A QUALITY SERVICE

Understanding the expectations of the public, staff, media and an organisation can sometimes be difficult. But proactive involvement of the public and staff will lead to a mutual understanding of needs and drivers for change; for example, why certain HPSS services require development to ensure safe and effective care and others do not. In addition, it will promote an understanding of the complexity of factors which determine why health and social care services will never be error free, but minimisation of the risk of error is important for service improvement and health and social care outcomes. But when things go wrong, people have a right to feel let down by the Service, to make a complaint and to seek redress if harm has been caused. Some organisations and staff have a tendency to think of these actions in a negative light because of fear of litigation, adverse media coverage and potential for destruction of reputation and career pathway. Both service users and staff need open and fair processes to investigate and determine the cause of what went wrong. For this to happen means that there are special responsibilities placed on the media, the public, service users and staff. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

4.4 CHANGING LOCAL COMPLAINTS PROCEDUES

The reporting and handling of complaints are also part of a learning culture. The public has a right to complain when concerned about their treatment or care. Complaints tend to be seen in a negative light, but nonetheless are a significant source of learning for individuals and organisations.

The Department is currently undertaking a review of the HPSS complaints procedures, with the aim of making complaints systems more effective for the public, staff and organisations. It is anticipated that a public consultation on the new procedures will commence in early 2006. This consultation will also incorporate some of the recommendations contained in the 5th Shipman Inquiry Report.

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In reviewing the HPSS complaints procedures, the aim is to:

- make procedures easier to access;
- be fair to all parties;
- respond to complaints in a timely way;
- emphasise early resolution;
- ensure the process is aimed at satisfying the complainant's concerns; and
- promote learning across the HPSS.

4.5 A SYSTEM OF REDRESS

Errors will happen and although most do not lead to harm, some will. But what happens when things go wrong and a service user is harmed? Not all service users and carers are content with the current system and sometimes find it hard to engage with HPSS organisations to find out what happened to themselves or to their loved one.

Openness is fundamental to the partnership between the service user and those who provide care. In support of that openness, people should be given an explanation of what has happened, an apology, reassurance, remedial treatment and compensation, where appropriate. A unified approach to redress should be developed. Effective redress will be part of the regional and local goal to promote a timely response for the service user. It will also set "error" in the context of learning in order to promote quality improvements within the HPSS.

4.6 COMMUNICATING SERIOUS INCIDENTS

All organisations should have a clear policy on how to communicate a serious incident to individuals, families and carers, staff and to the media, where appropriate. This policy should comply with best practice relating to the confidentiality of information, human rights, and privacy for service users and staff. The six major parts of this policy should include:

- a unified approach to redress (as identified above) for the individual, their family and carers;
- support for service users and carers during the course of an investigation and/or further treatment;
- support for individuals within the organisation to cope with the physical and psychological impact of what has happened;
- a timely inter-organisational communication system;

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- designated and trained key people within the organisation with responsibility for communication; and
- how and by whom the incident should be investigated.

KEY POINTS

- Individuals have responsibility for their own health, and that of their dependants.
- The HPSS, public and media need to work in partnership to promote public health and social well-being, and to enhance safety for service users and staff.
- Provision of information, in accessible format, to support decision-making in treatment and care, and to enhance safety, is essential for service users and carers.
- The public has a pivotal role in the prevention and detection of error.
- The public has a right to complain when concerned about their treatment or care. Complaints are a significant source of learning for HPSS organisations.
- The public and media have important responsibilities regarding the promotion of an open and fair culture, in order to prevent reoccurrence of incidents.
- Service users and staff need open and fair processes when a serious adverse incident is being investigated.
- Redress means having systems in place to offer an apology, reassurance, speedy remedial treatment, and compensation, if appropriate, when harm has been caused to an individual.
- All HPSS organisations should have an effective communication policy in place.

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SECTION 5 – ACTION PLAN AND STEPS TOWARDS SUSTAINABLE IMPROVEMENT

5.1 INTRODUCTION

In this section, the action plan and steps underpinning sustainable improvement in the HPSS are brought together in five key themes:

- implementing evidence–based best practice and learning from adverse events;
- agreeing common systems for collection, analysis and management of adverse events;
- sharing the learning;
- building public confidence; and
- promoting education, training and support for health and social care staff.

The audience for this action plan is HPSS managers, staff, educationalists and practitioners, including those working within the family practitioner services. The plan also includes action which will be undertaken by the DHSSPS as part of its commitment to safe and effective care. Given the broad nature of the safety and quality agenda, the plan does not aim to be all-encompassing but rather to focus on high level actions which need to take place in order to prevent adverse outcomes, and to improve service user, carer and staff experiences. It is seen as complementary to the many other initiatives which are ongoing in the HPSS primary, secondary and community sectors to improve health and social care outcomes.

The vision for the future is a safer service, where there is a systematic and co-ordinated approach to safety and quality. This requires staff, organisations and the public to work in partnership to promote a culture of learning, which is open and fair to service users, carers and staff, and one which minimises errors.

The following action plan will be reviewed and updated in 2007 to take account of progress and local and national developments.

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5.1.1 Implementing evidence based practice and learning from adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	Links to the National Patient Safety Agency will be agreed and guidance issued to the HPSS	Access to training, tool and guidance for the HPSS and the Department	April 2006
DHSSPS	A phased implementation plan to support joining the National Reporting and Learning System (NRLS) will be put in place	Triangulation of data sources, benchmarking and cascade of learning	June 2006
DHSSPS	All HPSS organisations will be part of NRLS	Triangulation of data sources, benchmarking and cascade of learning	December 2007
DHSSPS	Guidance on the nature of links to NICE and local pathways will be cascaded to the HPSS	Promotion of evidence based best practice	February 2006
DHSSPS	Following links with NICE, specific guidance on the introduction of new interventional procedures into the HPSS will be produced	Safer introduction of new diagnostic equipment and treatments.	April 2006
DHSSPS, CREST	CREST together with the Department will agree and publish the process for development of its annual work programme	Better linkage of regional priorities and audit programmes	June 2006
DHSSPS, CREST, RMAG	The Review of Regional Audit Arrangements will be implemented. Regional audit programmes will be linked to the wider safety and quality agenda	Better linkage to regional priorities and audit programmes	April 2006 Ongoing
RQIA	Will commence evaluation of HPSS quality of care	Assessment quality of care	From April 2006 ongoing

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5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	All organisations will adopt the definition of an adverse incident as identified in Section 1	Standardisation of definition and local data collection in adverse incidents	March - 2006 ongoing
DHSSPS, HPSS	All organisations will recognise the need for an informed safety culture	Supports timely reporting and an open, fair, flexible and learning culture	March 2006
DHSSPS	Better linkage on quality and safety agenda within Departmental structures	Integration of quality and safety issues	April 2006
DHSSPS, HPSS	Safety and quality will be a standing agenda item at board meetings	Senior management commitment to quality and safety	February 2006 and ongoing
HPSS	Organisations will have incident reporting levels reviewed at least quarterly by senior management	Regular analysis of adverse incidents and near misses	March 2006 ongoing
HPSS	All organisations will have a designated lead to determine when a serious incident investigation should be instigated	Clarity and consistency in handing investigation of major incidents	April 2006
DHSSPS, HPSS	Algorithms on common and specific reporting systems will be designed and cascaded for use in HPSS	Avoidance of duplication and clarity of reporting arrangements	September 2006
DHSSPS	Develop and publish policy guidance to clarify the role and function of Interim Arrangements for the Reporting of Serious Adverse Incidents	Clarity for the HPSS and the Department in the Reporting of Serious Adverse Incidents	February 2006
DHSSPS	Review local Interim Arrangements for the Reporting of Serious Adverse Incidents, in light of links with the NPSA's Patient Safety Observatory	Clarification of purpose and avoidance of duplication	April 2007
DHSSPS, HPSS	Regional Reporting Systems Project for primary and secondary care will be completed, and linked to joining with NRLS	Standardisation of definitions, reporting forms and coding of incidents	April 2007

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5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	A centralised database of clinical negligence claims will be developed	Enhanced data analysis and sharing the learning	December 2006
DHSSPS, in collaboration with PSNI, HSE, and Coroner's service	A Memorandum of Understanding will be published on the investigation of unexpected death or serious harm, which will complement existing procedures and processes for protection of children and vulnerable adults	Promoting communication and shared working between the public sector	March 2006
DHSSPS	Further guidance will be issued on how and when to investigate a serious adverse incident	Clarity and consistency in handling investigations	September 2006

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5.1.3 Sharing the learning			
Responsibility	**Action**	**Purpose**	**Completion date**
HPSS, including FPS	Each organisation will have a policy on incident management which will be endorsed by senior management and will be regularly reviewed	Consistency of approach in incident management and learning throughout the organisation	March 2006
DHSSPS, HPSS including FPS	Each organisation will demonstrate a multidisciplinary team approach to reducing risk and improving reporting	Engagement with staff. Consistency of approach in incident management and learning throughout the organisation	April 2006
HPSS including FPS	Each organisation will have a feedback mechanism in place when an incident is reported by an individual or team	Facilitation of action, learning and service change	March 2006
DHSSPS, HPSS	Where a major incident has been identified locally, local solutions will be designed by convening a panel of experts and/or building into existing programmes e.g. CREST, NPSA	Facilitation of action, learning and service change	Ongoing
DHSSPS	An annual report on local serious adverse events will be issued to the HPSS	Sharing the learning and implementing change	March 2006 and Ongoing
RQIA	Following investigation of specific serious adverse incidents, RQIA will produce and cascade a report	Cascade of learning and prevention of reoccurrence of adverse incident	April 2006 and ongoing
DHSSPS, HPSS	A review of communication channels will be undertaken by the Department to include; - consideration of links with SABS, a gateway approach to provision of information, revision of departmental website “governance” pages and extranet access on the results of root cause analysis in the HPSS	Enhanced communication, timely distribution of urgent communications and sharing of learning	December 2006

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

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	Organisations will recognise that health and social care will never be error–free, but patients, clients, service users and carers have an important partnership role to play in identification and reduction of errors	Better information to service users and acknowledgement of their role as partners in care	February 2006 Ongoing
DHSSPS, HPSS	Organisations will have a policy on how to communicate a serious adverse incident to individuals/families/staff and the media	Better information and coordination of communication with stakeholders	April 2006
DHSSPS in collaboration with NISCC	A programme for roll-out of registration for the social care workforce will be agreed and commenced in April 2006	Enhanced regulation of the workforce	April 2006
DHSSPS	A public consultation will be undertaken on a new HPSS complaints system	Improved openness, transparency and learning	April 2006
DHSSPS, in collaboration with HPSS	Guidance on redress, where harm is caused to service users, will be developed and implemented in the HPSS	Supporting openness, an apology, an explanation, remedial treatment and compensation, where appropriate	December 2006
DHSSPS, in collaboration with HPSS	A composite set of safety/quality performance indicators will be developed encompassing clinical and non-clinical care, and social care	Enhanced accountability and performance management on safety and quality	July 2006
DHSSPS	New Primary Care legislation will be introduced to enhance the role and functions of the Health Service Tribunal and powers of the HSS Boards	Improved procedures for considering the conduct or performance of family practitioners	November 2006
DHSSPS, HPSS Boards and Trusts	A specific project will be convened to consider key elements to enhance safety and communication at the interface of primary and secondary care	Enhanced safety and quality of care at the interface of primary and secondary care	February 2007
DHSSPS, HPSS Boards, Primary care	Medicines Governance Team Programme will extend into primary care	Promotion of medicines risk management and improvement in quality of	January 2006 Ongoing

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

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
practitioners Medicines Governance Team		care	
DHSSPS	A Northern Ireland response to Shipman Inquiry Report Recommendations will be consulted upon and published	Improved professional practice and public protection	July 2006
DHSSPS	A review of existing appraisal systems (medical) will be undertaken	Improved professional practice and public protection	January 2006
DHSSPS	Following the outcome of Donaldson & Foster reviews on professional regulation, implementation of national recommendations will be implemented	Improved professional practice and public protection	Date to be determined
DHSSPS	The Department will publish guidance on Protecting Personal Information	Supports confidentiality and implementation of professional practice and legislation	January 2006
DHSSPS	Guidance on a new disciplinary framework for employed doctors and dentists will be published and implemented in the HPSS	Improved procedures for considering the conduct or performance of doctors/dentists in the HPSS	February 2006
CREST, DHSSPS, HPSS	All organisations will implement CREST guidance on Inter-hospital transfer of medical records	Reduction of risk to service user, when transferred in or between HPSS establishments	April 2006
HPSS	HPSS will complete implementation of the Hine Review on endoscope decontamination	Consistent approach to disinfection and decontamination of endoscopes	July 2006
DHSSPS, HPSS	A response to the O' Hara Inquiry Recommendations will be published and implemented	Safer care for sick children who require intravenous fluid	Date to be determined
DHSSPS, HPSS, in collaboration with Universities, CREST RMAG NIPEC,	The recommendations from the RQIA report on *Review of the lessons arising from the death of Mrs Janine Murtagh* will be implemented	Consistent and improved approach to consent, pre and post operative care, leadership and communication, and the implementation of policies and procedures	March 2007

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

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
NIMDTA			
DHSSPS	A Regional Procurement Strategy, incorporating safety, will be published for the HPSS	Safer health service procurement, design and practice	January 2006

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

5.1.5 Promoting education, training and support for all health and social care staff			
Responsibility	**Action**	**Outcome**	**Completion date**
HPSS	All HPSS organisations will include risk awareness within induction programmes to the organisation, and in specific areas of care	Awareness of risk and of organisational reporting policies and procedures	April 2006 Ongoing
DHSSPS, in collaboration with NIMDTA	A project will be convened to consider the generic contents of an induction programme for new doctors, building on recent learning from adverse events	Standardisation of induction, for new doctors	February 2006
DHSSPS, in collaboration with Universities, NIPEC, NICPPET, NIMDTA NISCC NPSA	Discussion will be held with key stakeholders to incorporate risk awareness, and adverse incident policies and procedures into basic training modules, including specific high risk areas such as medicines, medical devices and child protection issues	Promotion of safety and quality and cascade of learning	December 2006

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5.2 CONCLUSION

Safety First: A Framework for Sustainable Improvement in the HPSS sets out a clear policy direction to improve quality of care. This policy and action plan is part of the modernisation and reform agenda and places safety and quality at the heart of good governance.

It recognises that major steps are needed to promote partnership working and enhance public confidence in the services provided. Support, training and education of staff are vital to its success.

The action plan will be reviewed in 2007 to assess progress on implementation. Quality and safety are part of good governance and will be reported on by the HPSS Regulation and Quality Improvement Authority. In addition, the action plan will form part of the ongoing accountability review processes for HPSS organisations, including primary care practitioners. A number of quality and safety performance indicators will be developed as part of implementation of the action plan.

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

GLOSSARY

ACCREDITATION

Formal recognition or approval of a service or training programme from a recognised authority e.g. a royal college.

ADVERSE EVENT OR INCIDENT

Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

CARER

A carer is an individual who looks after someone who is unwell and/or who requires special assistance to manage their complex needs or situation.

CLINICAL AUDIT

A quality assessment and improvement mechanism in which healthcare professionals peer review their practice, compare it to best practice and introduce improvement in line with their findings.

Clinical and social care audit is interpreted as multi-disciplinary or multi-professional audit, involving a wide range of clinical and social care professions, with inputs from all its constituent groups working together or in single disciplines.

CLINICAL AND SOCIAL CARE GOVERNANCE

A framework through which local organisations are accountable for the quality of service they provide.

CLINICAL NEGLIGENCE

Failure to exercise a reasonable standard of care appropriate to the circumstances, resulting in unintended injury, loss or death to another party.

CULTURE

The general customs and beliefs, of a particular organisation at a particular time. 'How we do things around here.'

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HEINRICH RATIO

A proactive check on a systems “vital signs”- The Heinrich ratio of one major injury to twenty nine minor injuries to three hundred no-injury incidents.

HOMICIDE

An act of murder.

HOSPITAL AND SOCIAL CARE EPISODE STATISTICS

Statistics on hospital and social care episodes of care, e.g. admissions, outpatients appointments, domiciliary care hours provided.

INTELLIGENCE MECHANISMS

The mechanisms for the collection and co-ordination of data.

MEDICINES GOVERNANCE

A focus on risk management involving the prescription, supply, dispensing administration and disposal of medicines. It aims to improve patient & client care through a programme of continuous improvement in medicines management.

NEAR MISS

An unexpected or unintended incident that was prevented, resulting in no harm.

RISK REGISTER

A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.

SERVICE LEVEL AGREEMENT

A service level agreement is a document, which defines the relationship between two parties: the provider and the recipient.

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SERVICE USER

Anyone who uses, requests, applies for, or benefits from health and social care services. They may also be referred to as clients, patients or consumers.

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ABBREVIATIONS AND ACRONYMS

CEMACH

Confidential Enquiry on Maternal and Child Health.

CISH

Confidential Inquiry into Suicides and Homicides by people with mental illness.

CREST

Clinical Resource Efficiency Support Team.

CSCG

Clinical and Social Care Governance.

DHSSPS

Department of Health, Social Services and Public Safety (Northern Ireland).

DIS

Directorate of Information Systems (DHSSPS).

FPS

Family Practitioner Services- e.g. general medical practitioners, community pharmacists, general dental practitioners, and optometrists.

GB

Great Britain.

GDC

General Dental Council.

GMC

General Medical Council.

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HPSS

Health and Personal Social Services commissioning and providing treatment and care in hospitals, communities and through family practitioner services.

HRD

Human Resources Directorate (DHSSPS).

HSENI

Health and Safety Executive Northern Ireland.

IHI

Institute for Healthcare Improvement in the United States of America.

MHRA

Medicines and Healthcare products Regulatory Agency.

MRSA

Methicillin-Resistant Staphylococcus Aureus.

NCAS

National Clinical Assessment Service now part of NPSA but previously the autonomous NCAA (National Clinical Assessment Authority)

NCEPOD

National Confidential Enquiry into Patient Outcome and Death.

NHS

National Health Service.

NI

Northern Ireland.

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NIAIC

Northern Ireland Adverse Incident Centre.

NICE

National Institute for health and Clinical Excellence.

NIMDTA

Northern Ireland Medical and Dental Training Agency.

NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery.

NICPPET

Northern Ireland Council for Pharmaceutical Postgraduate Education and Training.

NISCC

Northern Ireland Social Care Council.

NPSA

National Patient Safety Agency.

NRLS

National Reporting and Learning System.

PCD

Primary Care Directorate (DHSSPS).

PPMD

Planning and Performance Management Directorate (DHSSPS).

RMAG

Regional Multi-professional Audit Group.

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RQIA

Health and Personal Social Services Regulation and Quality Improvement Authority.

SABS

Safety Alert Broadcast System.

SAI

Serious Adverse Incidents.

SCD

Secondary Care Directorate (DHSSPS).

SCIE

Social Care Institute for Excellence.

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APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

The terms of reference for this project are as follows:

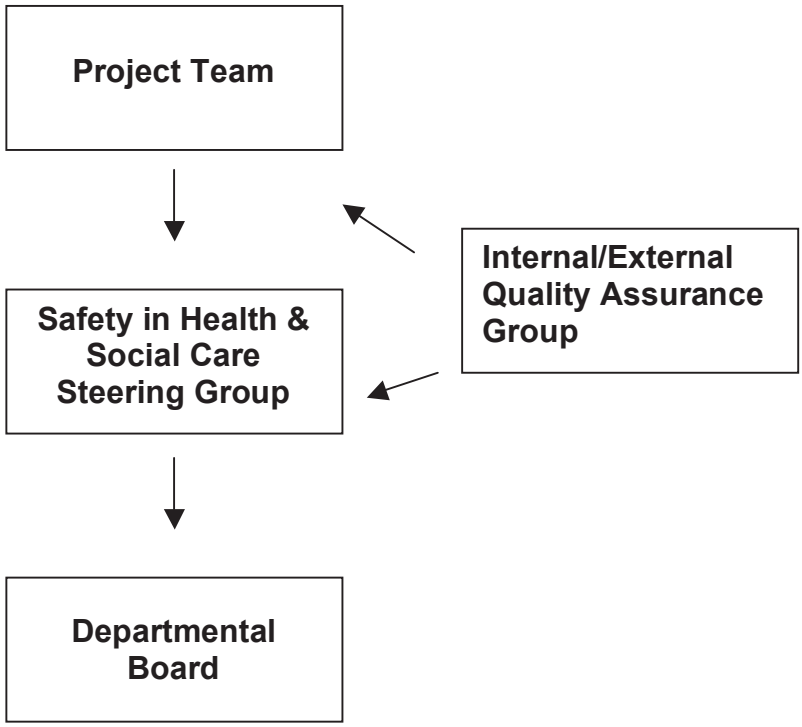
Service user and staff safety concerns everyone who uses or works in the HPSS. The safety policy framework will:

- identify the key components of a safety policy;
- consolidate good practice;
- promote and support an open and fair safety culture;
- link local objectives and priorities, with national developments;
- build capacity and capability at local level; and
- embed service user and staff safety in everyday practice, clinical and social care governance systems and health and social care environments.

The safety framework will be accompanied by an action plan, which will identify key tasks to be taken forward by the Department and the HPSS. This policy framework and action plan will be reviewed in early 2007.

Reporting arrangements

The Safety in Health and Social Care Steering Group will act as the steering group for this project. This Group will report to the Departmental Board by early September 2005.



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Safety in Health and Social Care Steering Group

Chair: Dr Ian Carson – Deputy Chief Medical Officer, DHSSPS

Members: Mr Jonathan Bill, DHSSPS
Ms Tracey Boyce, RGH
Mr Brian Godfrey, DHSSPS
Dr Maura Briscoe, DHSSPS
Dr Glenda Mock, DHSSPS
Mr Don Hill, DHSSPS
Ms Irene Low, Ulster Community Hospitals Trust
Ms Nicola Kelly, Belfast City Hospital Trust
Ms Yvonne Kirkpatrick, Belfast City Hospital Trust
Mrs Nuala McArdle, DHSSPS
Dr Norman Morrow, DHSSPS
Mr Pat Newe, DHSSPS
Mrs Elizabeth Qua, DHSSPS
Mr Robert Sergeant, DHSSPS
Mrs Heather Shepherd, Regional Governance Adviser HPSS
Mrs Doreen Wilson, DHSSPS

The Project Team

The project team will comprise:

Mrs Heather Shepherd – Regional Governance Adviser, HPSS
Dr Maura Briscoe – Medical & Allied Group (lead), DHSSPS
Mr Jonathan Bill- Planning & Performance Management Directorate, DHSSPS
Ms Tracey Boyce – Medicines Governance Advisor, NI Medicine Governance Team, Royal Group Hospitals Trust
Mr Brian Godfrey – Health Estates Agency, DHSSPS
Mrs Liz Qua - Health Estates Agency, DHSSPS
Mr Pat Newe – Social Services Inspectorate, DHSSPS

Secretariat – Mr Jonathan Wright, Medical & Allied Group, DHSSPS

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Quality Assurance Group

There will be a virtual QA Group comprising nominees from:

- Primary Care Directorate DHSSPS;
- Secondary Care Directorate DHSSPS;
- Community Care Directorate DHSSPS;
- Human Resources Directorate DHSSPS;
- Best Practice, Best Care Steering Group;
- Finance Management Directorate (Claims and Litigation) DHSSPS;
- Public Safety Unit DHSSPS;
- Planning and Performance Management Directorate DHSSPS;
- Professional Groups within the DHSSPS;
- Health and Personal Social Services Regulation and Quality Improvement Authority;
- Health Estates Agency DHSSPS;
- Northern Ireland Social Care Council;
- Mr Howard Arthur, CGST, Modernisation Agency
- HPSS Trusts & Boards; and
- HSS Councils.

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APPENDIX B – EXAMPLES OF DATA SOURCES AND FINDINGS

Information Source	Examples of factors that will affect findings	Examples of findings
Incident reporting Systems	More likely to record near misses and errors which did not lead to harm. May be less likely to report known side effects and complications of treatment.	4.9 incidents reported for every 100 hospital admissions, and 1.2 incidents reported for every 100 bed days (England). 1.1 to 3.8 incidents for every 100 bed days (Regions, Pennsylvania, USA)[24]
Medical record review	The threshold that is used for including minor errors or deviations from standards of care. The threshold that is used for determining that harm to a patient was preventable.	Four to 17 adverse events in every 100 hospital admissions (studies in North America and Europe).
Routine data Collection	Recording of adverse events likely to be incomplete. Recording likely to improve with greater awareness of issues.	About two adverse events in every 100 hospital admissions in England[25]. 16 deaths from MRSA in every million men, and 8.5 deaths for every million women[26].
Surveys of patients and staff	Level of awareness of staff and patients. Patient's condition: for example, people with long-term conditions are more likely to be aware of errors than those receiving life-saving treatment.	35 in every 100 NHS staff reported seeing at least one error or near miss that could have harmed patients during the month before the survey[27]. 18 to 28 in every 100 patients with health problems from five countries believe a medical mistake or medication error affecting them had occurred in the two years before the survey[28].

Source:- *Building a memory: preventing harm, reducing risk and improving patient safety*. National Patient Safety Agency, July 2005.

[24] Department of Health. *Building a Safer NHS for Patients.* Available at www.doh.gov.uk/buildsafenhs (November 2003)
[25] Aylin P et al. How often are adverse events reported in English hospital statistics? *BMJ* 2004;329:369
[26] Office on National Statistics. *Health Statistics Quarterly.* Spring 2005:60-5
[27] Healthcare Commission. *NHS Staff Survey 2004: Summary Report.* March 2005
[28] Commonwealth Fund. *2002 International Health Policy Survey of Adults with Health Problems.* Available at: www.cmwf.org/surveys/surveys_show.htm?doc_id=228168

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APPENDIX C

RAISING AWARENESS OF RISK, AS PART OF AN INDUCTION PROGRAMME FOR NEW RECRUITS, AND THE TRAINING OF IN-SERVICE STAFF

To improve patient and service user safety, the education and training of all HPSS staff must include risk awareness. Inclusion of "risk awareness" is an integral part of the risk management standard included in Controls Assurance Standards, the HPSS Quality Standards and the Care Standards.

Particular attention needs to be paid to the induction of temporary staff to ensure that key policies and procedures relevant to their level of competence are known prior to the commencement of practice.

Induction and in-service training programmes, should include:

- an overview on the organisation's safety culture, policies and procedures;
- basic awareness of the systems approach to patient and service user safety;
- awareness that health and social care is a high risk industry and the importance of being risk aware;
- awareness of their own personal responsibilities within their specific areas of work;
- the current incident statistics for health and social care within the organisation;
- examples of how things can go wrong;
- why incidents happen;
- how to report incidents;
- the importance of working within one's own ability; and,
- practical skills to practise safely.

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APPENDIX D

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incidents Reporting and Management

Summary Version

The full version of this document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

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Contents

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1.0 Introduction

1.1 This is a shortened version of a document produced to assist Health and Personal Social Services organisations (HPSS) in developing or reviewing processes to assess incidents and their consequent risk implications. It has been written for senior managers responsible for reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the current systems and processes that HPSS organisations use to manage incidents. The tool has been developed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 HPSS and primary care organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The broad aim of this document is to facilitate better systems for sharing learning from adverse incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from events where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all adverse incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included; for example; social care, clinical, health and safety, fire, infection control etc.

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1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as;

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"

1.7 Further associated work in this area will include a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

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2.0 Stages of Adverse Incident Management (See Flowchart One)

Stage 1 – Incident occurs and is reported via the organisations' internal reporting mechanism to the organisations' central recording system. Incident details are communicated internally as necessary.

Stage 2 – Determine actual incident severity.

Stage 3 – Assess incident to determine immediate action required. Following initial assessment consider whether it is appropriate to report to external organisations (See flowchart for examples)

Stage 4 – Initiate incident investigation as appropriate. Consider whether it is appropriate to report to external organisations. (See examples of organisations requiring reports in Flowchart One)

Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe.
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (available in the full version of this document) to determine the risk severity.

Stage 6 – Use the Action Guidance to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register.

Stage 7 – Determine any local and regional learning and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations keep the future risk rating (Stage 5) under regular review.

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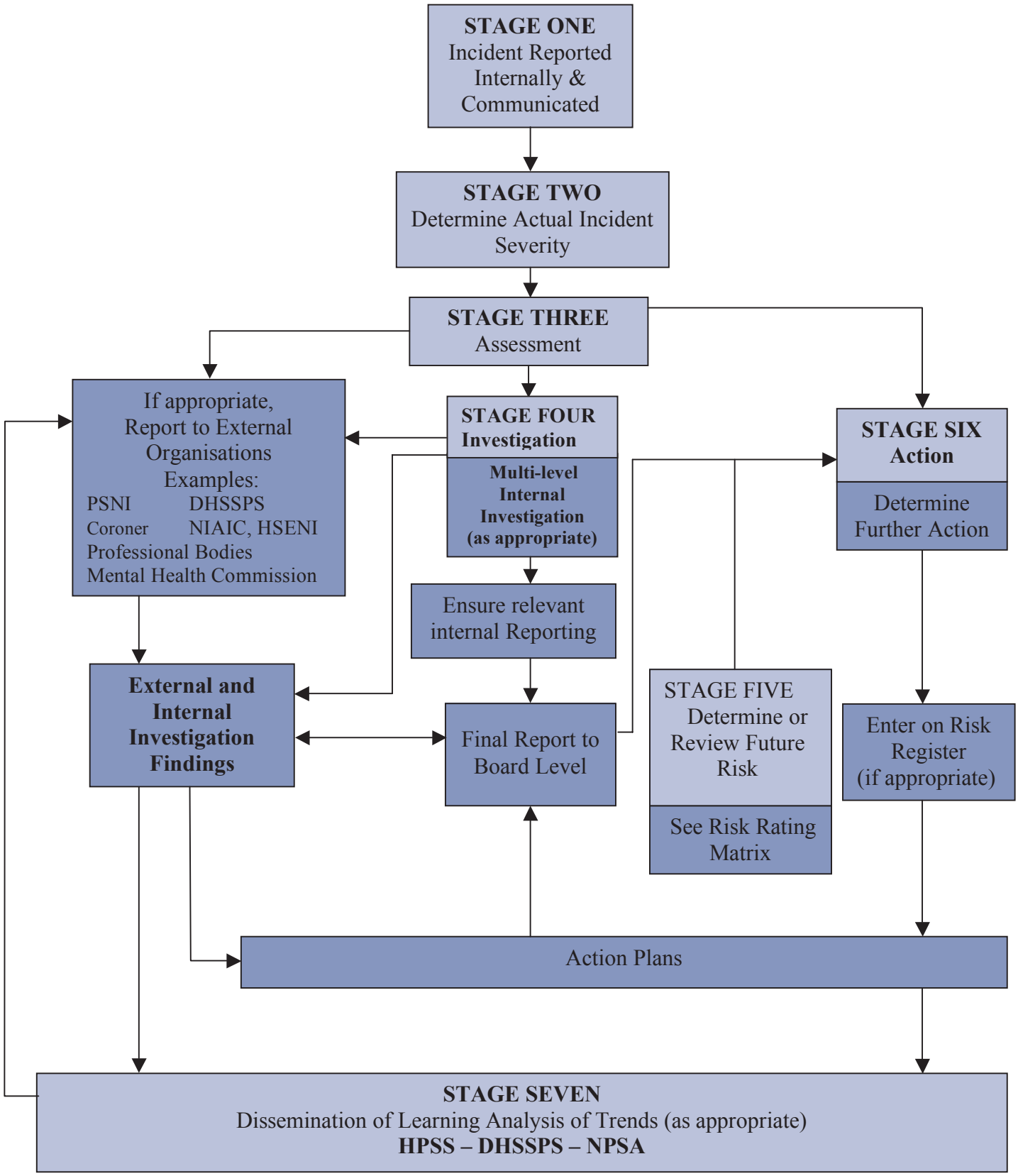
STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE



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APPENDIX E

PROMOTING EQUALITY AND HUMAN RIGHTS

Section 75 of the Northern Ireland Act 1998 requires the Department, in carrying out its functions, powers and duties, to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Members of the project team met to consider the equality and human rights implications of the safety framework and action plan. A screening exercise was undertaken, against four questions, which are identified below. The following text represents a summary of the discussion.

Is there any evidence of higher or lower participation or uptake by different groups?

The Group discussed the potential for greater integration of safety and quality policy development and action. It recognised that diminished standards on safety reflected a poor quality of treatment and care, for service users across the spectrum of care provided. Given the diverse nature of this framework, no one particular section 75 category would be disadvantaged. Indeed, the aim was to benefit all service users by promoting a safety culture, and a systematic approach to prevention, detection, reporting and management of adverse incidents. A part of this safety culture was the promotion of learning to prevent reoccurrence of incidents.

It was noted that whilst all people have the right to access HPSS services, greater use of these services are made by the very young, older people and those with complex needs and chronic conditions. The safety framework acknowledges the complexity of health and social care provision and environments. It advocates an open and fair culture which promotes involvement of all service users, particularly in relation to identification of risk and the part that service users, carers and the wider public have to play in the minimisation of that risk and in the development of solutions appropriate to their needs.

The safety framework links to the values and principles identified in the Quality Standards for the HPSS. These have been consulted upon;

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these values include equality, diversity, choice, rights and respect for the individual.

Is there any evidence that different groups have different needs, experience, issues and priorities in relation to the particular policy?

No. It was considered that religion, political opinion, racial group, marital status, sexual orientation, gender or disability had no direct impact on this high level policy document or action plan. It was noted that there was a full section contained in the framework on involving and communicating with service users, carers and the public. This recognised that all people had a right to complain when concerned about their treatment or care, and that appropriate redress was an integral part of a quality system, when things go wrong. It was felt that the action plan was a relatively high level one which brought together many different strands of the quality and safety agenda. The action plan also attributed action to a number of organisations. In such circumstances, there would be a general need to consider equality and human rights implications when implementing specific actions.

Is there an opportunity to better promote equality of opportunity or good relations by altering policy or working with others in government or the community at large?

Equality of opportunity and good relations will be promoted through development of this policy. The policy and action plan recognise the need for:

- Enhanced promotion of health and safety for **all** service users, carers, staff, practitioners and visitors;
- Development of organisational communication policies and the training of staff to enhance engagement with service users and carers;
- Promotion of good relations through development and support of an informed safety culture;
- Increase in the reporting of adverse incidents and shared learning of experience;
- A more systematic approach to redress, when things go wrong;
- Enhanced communication across primary, secondary and community care, and with other agencies, for example, police, Health and Safety Executive and coroners;

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- Increase in the availability of information and consultation on treatment and care with service users, carers and practitioners; and

- Enhanced education, training and development of staff.

How will this impact on complementary policy areas?

The safety framework and action plan complement other policy areas. It is part of the overall quality framework as set out in Best Practice Best Care (2001), which was subject to extensive consultation. Safety is an integral part of clinical and social care governance, care standards, controls assurance and quality standards. All of these developments are aimed at enhancing health and social care outcomes and the service user experience. The safety framework also supports other initiatives to promote continuous professional development, life-long learning and enhanced regulation of the workforce. The safety framework and action plan is underpinned by the Duty of Quality as outlined in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Conclusion

The safety framework is a high level document, which aims to bring together different strands of the wider safety and quality agenda. It draws on existing policy developments and identifies, in a single plan, actions which need to take place within the next two years to enhance safety within health and social care services. The project team concluded there was no adverse impact on equality or human rights arising from the safety framework. It was also noted that equality and human rights implications would be considered as part of the development and implementation of specific actions associated with the framework.

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APPENDIX F

REFERENCES, CIRCULARS AND GUIDANCE

CIRCULARS

NIAIC Safety Notice MDEA (NI) 2004/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.

Circular HSS (PPM) 3/2002 – Corporate Governance: Statement on Internal Control (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS(PPM)13/2002 – Governance in the HPSS – Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 20/2002 – Clinical Negligence: Prevention of Claims and Claims Handling (DHSSPS)

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (FAU) 19/2003 – Statement of Internal Control: Transitional Statement 2002/03(DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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Circular HSS (PPM)8/2004 – Governance in the HPSS: Controls assurance standards – update
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 2/2004 – Statement on Internal Control – Full Implementation for 2003/04 (DHSSPS)
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The Regulation and Quality Improvement Authority

Review of Consultant Medical Appraisal

Across HSC Trusts

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

Contents

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

1. SETTING THE SCENE

1.1 The Roles and Responsibilities of the Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Social Care (HSC) organisations and requires RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

1.2 Context for the Review

Medical consultant appraisal was introduced on 1 April 2001 and it is a contractual requirement for all consultants and employers.

Appraisal for consultants is designed to be a professional process of constructive dialogue in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved.

The aims and objectives of the appraisal scheme are[1]

- to review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources;
- to optimise the use of skills and resources in seeking to achieve the delivery of service priorities;
- to consider the consultant's contribution to the quality and improvement of services and priorities delivered locally;
- to set out personal and professional development needs and agree plans for these to be met;
- to identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met;
- provide an opportunity for consultants to discuss and seek support for their participation in activities for the wider HPSS;
- utilise the annual appraisal process and associated documentation to meet the requirements for GMC revalidation.

[1] Circular HSS (TC8) 3/01

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

The RQIA governance reviews in 06/07 assessed the achievement of HPSS Boards and Trusts against the first two themes of the HPSS Quality Standards[2];

- Corporate leadership and accountability of organisations;
- Safe and effective care.

Within the theme of Corporate Leadership and Accountability of Organisations a more detailed review was undertaken of appraisal of medical staff.

The 06/07 the RQIA overview report noted that there was significant variability in the uptake of consultant appraisal throughout the Trusts and at the time of the review there were a number of organisations that had not produced reports on consultant appraisal for Trust Boards. It was also noted that in some instances where reports had been produced, there was a lack of detail in several key areas.

The report recommended that all Trusts should ensure that annual consultant appraisals should be implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months). The report concluded that the area of consultant appraisal would be the subject of further scrutiny within the 07/08 review programme.

As a follow up to these recommendations the RQIA decided to carry out a desktop review, (using self assessment declaration) of consultant medical appraisal in 07/08. This report outlines the outcome of the desk-top review.

This review takes account of the arrangements in:

- Belfast HSC Trust
- Northern HSC Trust
- Southern HSC Trust
- South Eastern HSC Trust, and
- Western HSC Trust

1.3 Self Assessment

Self assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally. A self assessment proforma was developed (and submitted to trusts), based on the document "*Assuring the Quality of Medical Appraisal*" produced by the NHS Clinical Governance Support Team. The completed self analysis proforma together with supporting documentary evidence were returned to the RQIA for analysis. In meeting their legislative responsibility, the Chief Executive of each Trust signed a declaration confirming the accuracy of the self assessment return to RQIA.

[2] The Quality Standards for Health and Social Care. DHSSPS Mar 2006

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1.4 The Report

The report will be made available to the general public in print, at www.rqia.org.uk and in other formats on request.

In conducting this review, the RQIA acknowledges the significant organisational changes resulting from the merger of Trusts. It also acknowledges that the methodology of this review has led to limitations in the quality of information supplied by the Trust. The review methodology was not conducive to in-depth analysis nor did it allow examination of the implementation of policies and procedures. The views of appraisers and appraises were not sought. Therefore, the analysis of the effectiveness of the consultant appraisal system is limited.

The self assessment pro-forma was designed to undertake an initial assessment of the process of appraisal for consultant medical staff. It was not intended to explore all aspects of *"Assuring the Quality of Medical Appraisal".*

Following evaluation of this review the RQIA will work with the GMC, NIMDTA, PMETB, the Beeches Management Centre and Trust Medical Directors to develop an appropriate review methodology to assure the quality of medical appraisal in Northern Ireland.

2. FORMAT OF REPORT

The Clinical Governance Support Team in its report "*Assuring the Quality of Medical Appraisal*"[3] defined four high level indicators that would provide an indication that high quality appraisals were being undertaken.

1. **Organisational Ethos**
   There is unequivocal commitment from the highest levels of the host organisation to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

2. **Appraiser Selection, Skills and Training**
   The host organisation has a process for selection of appraisers and appraiser skills are continually reviewed and developed.

3. **Appraisal Discussion**
   The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan (PDP) prioritising the doctor's development needs for the following year.

[3] Assuring the Quality of Medical Appraisal. NHS Clinical Governance Support Team. July 2005.

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

4. **Systems and Infrastructure**
   The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

Within each of the high level indicators there are supporting criteria some of which will be used to assess the quality of the Trusts' assessments of their appraisal systems and processes.

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

3. ORGANISATIONAL ETHOS

The document *"Assuring the Quality of Medical Appraisal"* requires that under the heading of Organisational Ethos it should be demonstrated that there is **unequivocal commitment** from the highest levels of the host organisation to deliver a **quality assured system** of appraisal that is **fully integrated** with other systems of quality improvement.

3.1 Evidence of Organisational Commitment.

In order to demonstrate organisational ethos and commitment to appraisal the Trusts were asked to:

1) submit copies of current policies and procedures for annual appraisal / supervision for consultants and doctors in training, together with an organisational chart demonstrating the lines of accountability for the overall quality of medical appraisal;

2) provide the name of the doctor who has responsibility for leadership and the development of the consultant appraisal process;

3) describe the process for quality assuring the consultant appraisal process; how it is in integrated with other processes for Continuing Medical Education (CME) and clinical governance, and the Trust's commitment to time and resources to support appraisal system;

4) provide evidence of lay and public involvement in the consultant appraisal system;

5) indicate if an annual report on consultant appraisal is presented to the Trust Board.

Summary of the analysis of the Trusts' returns

Policy - all Trusts submitted a policy for appraisal of medical consultants setting out lines of accountability and giving an overall description of the appraisal process. Four of these were in draft form. Only the Northern Trust had an approved policy.

Accountability - all Trusts have similar lines of accountability for the appraisal system, with the Chief Executives having overall accountability to the Trust Board.

Clinical Leadership - the Medical Director on behalf of the Chief Executive, was identified as the person responsible for ensuring the integrity of the appraisal process and for monitoring the quality of appraisals undertaken. Lead clinicians in each department / directorate have responsibility for ensuring that arrangements are in place for all medical practitioners within their area of responsibility to have an annual appraisal. Individual consultants

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

are responsible for participating properly in the appraisal process and for completing their agreed personal development plan.

Quality Assurance - all Trusts stated that they followed the "*Good Medical Practice"* guidelines and that they use the recommended documentation They also reported that training needs identified through PDPs are supported in terms of time and resources by the relevant clinical directorate.

Lay and Public Involvement - none was reported.

Annual Report to the Trust Board - only the Southern Trust had developed an Annual Report to be presented to the Trust Board in early 2008. The other Trusts had plans to report to their Boards at the end of the appraisal year.

Number of Appraisals not undertaken - Trusts were also asked to supply information on the percentage number of consultants who had not been appraised during the period 1 April 2006 - 31 March 2007. They were also asked to provide the reasons why appraisals had not taken place.

Table 1. Percentage of consultants not appraised

Trust	% consultants not appraised	% locums not appraised
Southern	13% (17/122)	43% (7/16)
South Eastern	Estimated 40-50%	Information not supplied
Western	47%	Information not supplied
Northern	12%	42%
Belfast	28%	Information not supplied

Trusts provided a range of reasons for non-appraisal which included:

- changes in medical personnel during RPA had adversely affected the completion of appraisals;
- loss of momentum as a result of delay in finalising GMC arrangements for revalidation;
- posts not filled permanently and turnover in locum staff;
- doctors appraised but not returning paperwork to Human Resources;
- Sick leave.

Table 1 highlights that consultant appraisals are not given a high priority in some Trusts.

In acknowledging the recent significant organisational changes as a result of the mergers of the 18 Trusts into five new Trusts this may not be unexpected. Nevertheless, consultant appraisal has been in place since 1 April 2001 and is a contractual requirement for all consultants and employers. A key feature of new registration arrangements introduced by the GMC is the concept of Approved Practice Settings which are organisations approved by the GMC as suitable for doctors new to full registration or returning to the medical register after prolonged absence from UK practice. One of the key criteria of an approved practice setting is a system of annual appraisal for individual

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

doctors based on the principles of "Good Medical Practice" which is quality assured by an independent body or organisation.

Appraisal is also an important feature of revalidation which is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practice.

3.2 Evidence of Quality Assurance.

The following criteria were used to assess the quality assurance arrangements in place in respect of medical consultant appraisal;

- there is evidence of lay and public involvement in the appraisal system;
- quality assurance processes should include
    - an annual self assessment audit;
    - a three yearly objective assessment of the appraisal system by an appropriate independent group;
    - review of feedback questionnaires from appraisees;
    - appraisal summary forms and Personal Development Plans are reviewed annually and feedback given to the individual appraiser.

The final two points may also be used to review appraiser skills.

Summary of analysis of Trusts' returns

There was little evidence submitted that Trusts carry out an annual audit of medical appraisal systems. In the main, Trusts described an aspiration to meet the criteria outlined above. The Southern Trust was the only Trust to indicate that it carries out a yearly audit of 10 appraisal folders using the Quality Assurance Toolkit.

3.3 Evidence of Integration

The following Criteria were used to assess Trust submissions on evidence of the integration of appraisal systems into quality improvement and governance systems in the organisations.

- the appraisal system is integrated with other quality improvement systems in the host organisation e.g. continuing professional development and training, clinical governance, management of impaired clinical performance, workforce planning and human resources, risk management, service development, complaints;
- clear policies on the management of situations where a doctor's fitness to practice is impaired, including guidance on referral to National Clinical Assessment Service (NCAS) and General Medical Council (GMC);
- clear guidance on suspending appraisal when fitness to practice issues make it inappropriate to continue.

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

Summary of analysis of the Trusts' returns

In the Southern Trust, the Annual Consultant Appraisal Report and Quality Improvement Plan are reviewed by the Trust's Senior Management Team, the Integrated Governance Committee and the Trust Board. Appraisal documentation reflects on relationships with patients and make reference to complaints and other governance processes.

In the Southern, South Eastern and Western Trusts there was an indication that the appraisal documentation also includes a statement of continuing Medical Education (CME) activities for discussion within appraisal. The Western Trust indicated that clinical governance issues are also covered by consideration of specific records of audits, clinical incidents, complaints and peer reviews.

The Northern Trust reported that a variety of governance processes are referred to appraisals. These include complaints, critical incident reporting and medico-legal claims. Doctors were expected to include this information in the appraisal documentation. The Trust also indicated that activity and outcome information was also used in the appraisal discussion where this is relevant and available.

All Trusts indicated that they had a policy in place to discuss problems arising from the appraisal process and for dealing with any underperformance issues identified during appraisal.

It is recommended in "Assuring the Quality of Medical Appraisal" that the appraisal system should be fully integrated with other quality improvement systems in the Trust. This should include in all cases, clinical governance information such as audit, adverse incidents, evidence of underperformance and complaints.

Trust self assessment returns and submitted appraisal policies do not demonstrate that the appraisal system has been sufficiently integrated with all other Trust quality improvement processes.

4. APPRAISER SELECTION, SKILLS AND TRAINING

All Trusts are required to have in place a process for selecting appraisers and ensuring that appraiser skills are continually reviewed and developed.

In order to demonstrate appraiser skills and training Trusts were asked to submit:

1) Procedures for selecting and recruiting medical staff appraisers (including job descriptions and person specification requirements);

2) A description of the training arrangements for medical staff appraisers;

3) A description of how medical appraisers were supported in their role;

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4) Their policy on the minimum and maximum number of appraisals completed by each appraiser annually;

5) A description of the arrangements for assessing individual doctor's appraisal skills.

The Trusts' submissions were subsequently assessed against the following criteria

- recruitment of appraisers uses a defined person specification and job description (which are included in a wider person specification/job description if appraisal is part of a wider role);
- the appraiser must participate in initial appraiser training;
- there are systems to ensure that initial training effectively addresses appraiser needs;

Summary of analysis of the Trusts' returns

The Southern Trust indicated that it uses a generic person specification as proposed for all NHS organisations and generally the speciality lead adopts the role of appraiser with support of the Clinical Director / Associate Medical Director. All Trusts indicated that the job description for an Associate Medical Director (or equivalent) and Clinical Director also includes responsibility for appraisals.

The Belfast and Northern Trusts indicated that they only used experienced clinicians with extensive local knowledge as appraisers to ensure continuity in its first year of the Trust's existence

The South Eastern Trust appointed Clinical Managers through seeking expressions of interest from consultants working internally within the speciality or directorate. They did not have a specific policy for the recruitment of appraisers. In the Western Trust the generic NHS person specification was included in the policy document. The Medical Director took responsibility for recruiting appraisers through a process of volunteering or nomination by the clinical director.

All Trusts indicated that they used the formal training programme run by the Beeches Management Centre for the initial training of appraisers. Only the Belfast Trust indicated that the training was verified by senior medical managers.

None of the Trusts reported that they had adopted a formal process for selecting appraisers. This is something they may wish to consider as the Trusts mature following their establishment.

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

4.1 Evidence of Review and Development of Skills

The following criteria were used to assess evidence of the review and development of appraisal skills.

- there are systems in place for appraisal and performance management of appraisers;
- there are systems in place to ensure that appraisers participate in on-going training and development and that training is effectively addressing appraiser needs;
- there is guidance regarding the minimum and maximum number of appraisals per appraiser per year;
- there is a process for periodically assessing appraiser skills e.g. anonymous review of appraisal summary forms and PDP.

Summary of analysis of the Trusts' returns

The Southern Trust indicated that it undertakes audit to assess and summarise recurrent themes identified in the process for each appraiser. The Northern Trust stated that it had carried out an appraisee satisfaction survey in the past but had no current specific method for reviewing appraiser skills.

The remaining Trusts did not indicate that they had or were reviewing the skills of appraisers.

All Trusts indicated that appraisers receive on-going training but it is unclear from their submissions to whether this is a regular process, although the Northern Trust indicated that training is carried out on a three-yearly basis.

All Trusts stated that they have guidance in place on the maximum and minimum number of appraisals per appraiser per year.

Analysis of the information shows that there appears to be no formal process for review and performance management of appraisers and little evaluation of the effectiveness of the appraisal discussion. This is vital in informing issues to be covered in ongoing training and development of appraisers.

5. THE APPRAISAL DISCUSSION

It is a requirement that the appraisal discussion is challenging and effective. It should be informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a PDP prioritising the doctor's development needs for the coming year.

In relation to the appraisal discussion, the self assessment pro-forma asked Trusts to:

1) Describe the process for reviewing Appraisal Summary Forms and PDPs;

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2) Provide results of the most recent review of the appraisal forms in use, and any developmental action taken;

3) Describe the procedure followed should problems arise within the appraisal process;

4) Describe the process for dealing with serious underperformance issues identified during the appraisal discussion;

5) Describe arrangements in place to ensure that the needs of personal development plans are supported by the relevant clinical directorate;

6) Provide numbers of practitioners referred to NCAS or GMC as a result of an appraisal interview.

5.1 Evidence that the Appraisal Discussion is Challenging and Effective.

The following criteria were used to analyse the Trusts' self-assessment returns relating to the nature of the Appraisal discussion:

- the previous year's PDP is reviewed;
- a new PDP is produced;
- colleague and patient feedback is discussed;
- there is evidence of a change of appraiser after a maximum of three appraisals;
- performance management and development systems address challenge within the appraisal discussion.

Summary of analysis of the Trusts' returns

It would appear from the Trusts' submissions that there is evidence that individual PDPs developed at the time of appraisal are used to inform the appraisal discussion and in some instances are used to assess the appropriateness of continuing medical education of individual clinicians. Although there was evidence in Belfast, Western and South Eastern Trusts that senior medical managers review and sign off the PDPs, this needs to be formalised and integrated into the wider governance processes of the individual organisations.

It would appear that PDPs are not reviewed and feedback given to individual appraisers on content and quality.

There is no evidence within the Trusts' submissions that there is a change of appraiser after a maximum of three appraisals. It was indicated that this was difficult to achieve in the smaller sub specialities and in some small directorates.

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5.2 Evidence of Valid and Verifiable Supporting Evidence

The following criteria were used to analyse the Trusts' returns relating to valid and verifiable supporting evidence of the clinician's practice at the time of appraisal.

- there is a core portfolio of supporting evidence which reflects the breadth of the doctor's practice and conforms to national, GMC and Royal College standards and guidance;
- the supporting evidence includes feedback from patients and colleagues;
- there is guidance and training for appraisers for situations when evidence is insufficient.

Summary of analysis of the Trusts' returns

Analysis of the Trusts' returns was inconclusive in providing assurance that evidence from patients and colleagues forms part of the appraisal discussion in all Trusts. However, the Western Trust indicated that patients and clients are involved in 360 degree feedback. The Belfast and Northern Trusts are piloting a programme of 360 degree feedback.

It is unclear if there is any guidance on what would be regarded as sufficient and appropriate evidence for an appraisal and also unclear if there is any guidance for appraisers for these situations.

6. SYSTEMS AND INFRASTRUTURE SUPPORTING APPRAISAL

6.1 Evidence of Effective Supporting Systems and infrastructure

It is a requirement that the supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

The following criteria were used to analyse the Trusts' returns in respect of support systems and infrastructure;

- there is dedicated administrative support for the appraisal system;
- there is clearly identified managerial responsibility for the appraisal;
- adequate notice is given to prepare for the appraisal discussion;
- there is protected time for the appraisal discussion;
- there is guidance on potential conflicts of interest between appraiser and appraisee;
- there is guidance on the environment within which the appraisal discussion takes place;
- there is a system for handling complaints about appraisal.

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Summary of analysis of the Trusts' returns.

Each Trust supplied an organisational chart that demonstrated the lines of managerial accountability and responsibility for the overall quality of medical appraisal. They also indicate that they provide guidance on appraisal planning and timescales for agreeing date of appraisal, sharing of documentation and setting of the agenda for the appraisal discussion.

Trusts also indicated that they provide clear guidance on potential conflicts of interest prior to the appraisal discussion and on any issues or difficulties arising from the appraisal discussion and clear guidance on an environment for the appraisal discussion that guarantees privacy and confidentiality.

It was notable that the Southern Trust reported that they had clearly identified four hours of Special Programmed Activity (SPA) time for appraisers. This was allocated for preparation and conduct of each appraisal. Appraisees were allocated eight hours of SPA time annually for appraisal.

Although guidance has been provided on conflicts of interest and issues arising at the time of the appraisal discussion, it is unclear from the self assessment returns if there was a formal appeals mechanism which appraisees can access after appraisal has taken place.

7. CONCLUSIONS

Annual appraisal for all doctors was a recommendation in the Chief Medical Officer's report "*Supporting Doctors, Protecting Patients*". Consultant medical appraisal was introduced in April 2001 and is now a contractual requirement for all doctors working in the NHS. Appraisal should be an integral part of an organisation's governance systems and processes. Satisfactory delivery of appraisal should be a factor in delivering the quality and safety agenda.

A DHSSPS review of medical appraisal in Northern Ireland was published in January 2006 and it made several recommendations in relation to Consultant appraisal:

1) Trusts should have written policies for appraisal covering all medical staff;

2) Job descriptions with specific competences should be created for appraisers and should be integral to all job descriptions for Medical Directors, Clinical directors and Heads of Department;

3) Training requirements, including update training should be specified and appraisers not meeting those requirements should be removed from the list of appraisers;

4) Trusts should develop a minimum data set to support appraisal which will help to ensure consistency easing time pressures;

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5) Every Trust should produce an annual report for the Trust Board covering all doctors holding contracts of employment at the Trust and reporting uptake. The report should include an evaluation of the appraisal process, including those benefits arising for patients/carers and for doctors and should assess the extent to which objectives in Personal Development Plans align to the corporate agenda.

While some of these recommendations have been met / partially met a number still require further work to assure compliance.

The Trust returns indicate that in certain areas there is a significant shortfall in the number of consultants and possibly locums that have been appraised, this is concerning given the fact that the requirements for appraisal have been in place since April 2001.

There is an indication from Trusts that there are organisational structures in place demonstrating lines of managerial responsibility and accountability. However, there is no formal system for review and performance management of appraisers and there is little evidence of the evaluation of training and of the outcomes of the appraisal process.

This is the second occasion that RQIA have sought assurance on the structure and functions in HSC organisations in respect of consultant appraisal. Including the Departmental review published in 2006 it is the third time that the consultant appraisal system has been reviewed and recommendations made and yet this review indicates that there is still significant variability in the provision of consultant medical appraisal and also significant variability in appraisal systems across Trusts.

The RQIA acknowledges the difficulties associated with the merger of the Trusts and also has acknowledges that the review methodology has led to limitations in relation to the quality of information supplied by the Trusts. The desktop methodology does not permit in depth analysis of the appraisal system nor scrutiny of the effectiveness of the implementation of policies and procedures. It also does not include the views of appraisers and appraises. The effect of this is to limit the analysis of the effectiveness of the consultant appraisal system.

The self assessment proforma did not explore in sufficient detail all aspects of the document *"Assuring the Quality of Medical Appraisal"* and specifically did not investigate in sufficient depth the status of locum appraisal and appraisal for doctors in training.

In the future RQIA will:

1) consider a more robust methodology for further scrutiny of consultant medical appraisal including a refined self assessment document and visits to trusts by an RQIA review team;

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2) work with other stakeholders such as the GMC and perhaps the Beeches Management Centre in developing a more robust assurance tool;
3) work with other agencies such as NIMDTA and PMETB to assure the quality of appraisal of all categories of doctors;
4) work with trust Medical Directors to develop a system for assurance of medical appraisal consisting of an annual electronic return with assurance visits on a periodic basis.

8. SUMMARY OF RECOMMENDATIONS

While there is an opportunity to make detailed recommendations across a range of key criteria in the delivery of effective consultant and locum medical appraisal systems this would be more appropriate following a more robust review.

Trusts should be aware that Consultant medical appraisal has been in place since April 2001 and is a contractual requirement for all doctors working in the NHS. Satisfactory delivery of appraisal is a significant part of the quality and safety agenda.

RQIA recommends that all Trusts should as a matter of urgency comply in full where possible with the four high level indicators outlined in *"Assuring the Quality of Medical Appraisal"* and with the sub criteria outlined within this report. Trusts should also note the recommendations contained in *"Assuring the Quality of Training for Medical Appraisers".*

Trusts should indicate how they propose to comply with the above criteria and how they will ensure that all medical personnel are appraised, in an action plan to RQIA no later than the 30th November 2008.

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RQIA Reviews

1. RQIA reviews provide assurance to the public about the quality, safety and availability of health and social care services in Northern Ireland. The reviews aim to encourage continuous improvements in health and social care services and ensure the rights of service users are safeguarded.

Links to Relevant RQIA Reviews 2008 - 2021

- Review of Consultant Medical Appraisal Across HSC Trusts September 2008

[redacted]
Irrelevant redacted by the USI

Governance Reviews 2008
RQIA has published its reviews of clinical and social care governance arrangements in health and social care boards, trusts and agencies across Northern Ireland. The findings from its reviews demonstrate how the concepts and practicalities of clinical and social care governance and risk management are being taken forward in health social care organisations across Northern Ireland.

- Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland Overview Report - February 2008

rqia report.indd

- Review of Clinical and Social Care Governance arrangements in Health and Social Care Trusts in Northern Ireland Overview Report 2008

07933 RQIA report.indd

- BHSCT

CONTENTS (rqia.org.uk)

- NHSCT

3 (rqia.org.uk)

- WHSCT

3 (rqia.org.uk)

- SEHSCT

3 (rqia.org.uk)

- SHSCT

CONTENTS (rqia.org.uk)

- NI Ambulance Trust

CONTENTS (rqia.org.uk)

Readiness for Medical Revalidation December 2010

- Review of HSC Trust Readiness for Medical Revalidation Summary Report For Northern Ireland Dec 2010

Microsoft Word - RQIA Revalidation OVERALL NI final report 141210.doc

- BHSCT

  Microsoft Word - RQIA Review of Readiness for Revalidation Belfast Trust final report 210910.doc

- NHSCT

Microsoft Word - RQIA Review of Readiness for Revalidation Northern final report210910.doc

- SEHSCT

Microsoft Word - RQIA Review of Readiness for Revalidation SE trust final report210910.doc

- WHSCT

Microsoft Word - RQIA Review of Readiness for Revalidation WHSCT final 10910.doc

- SHSCT

Microsoft Word - RQIA Review of Readiness for Revalidation Southern final 210910.doc

- Review of Governance Arrangements in HSC Organisations that Support Professional Regulation January 2017

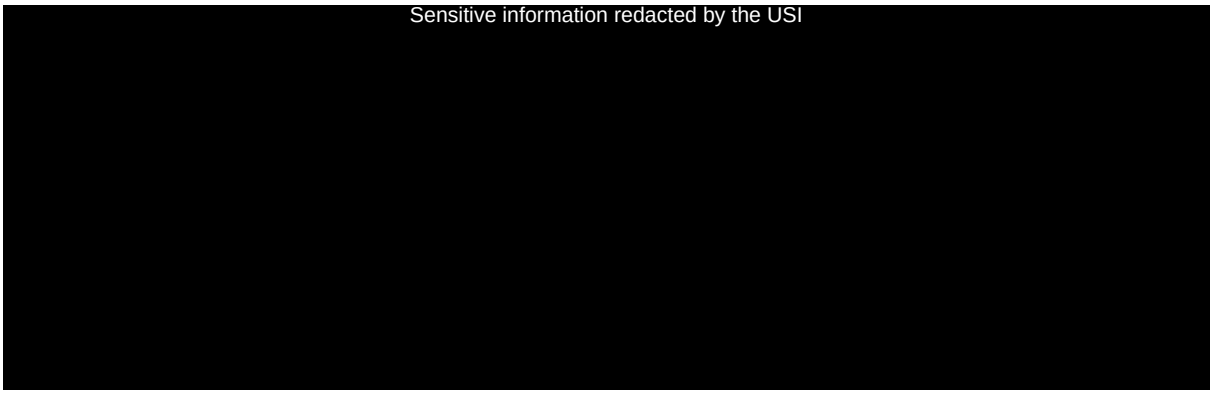
93721 RQIA Coloured Report Template (Reviews Directorate) Version002.indd

Review of Governance of Outpatients Services in the Belfast HSC Trust with a Focus on Neurology and other High Volume Specialties February 2020

Version 0_2 (rqia.org.uk)

- Review of Governance Arrangements in Independent Hospitals and Hospices in Northern Ireland June 2021

Microsoft Word - IVFluids_Final_Report_toPublish_220920 (rqia.org.uk)



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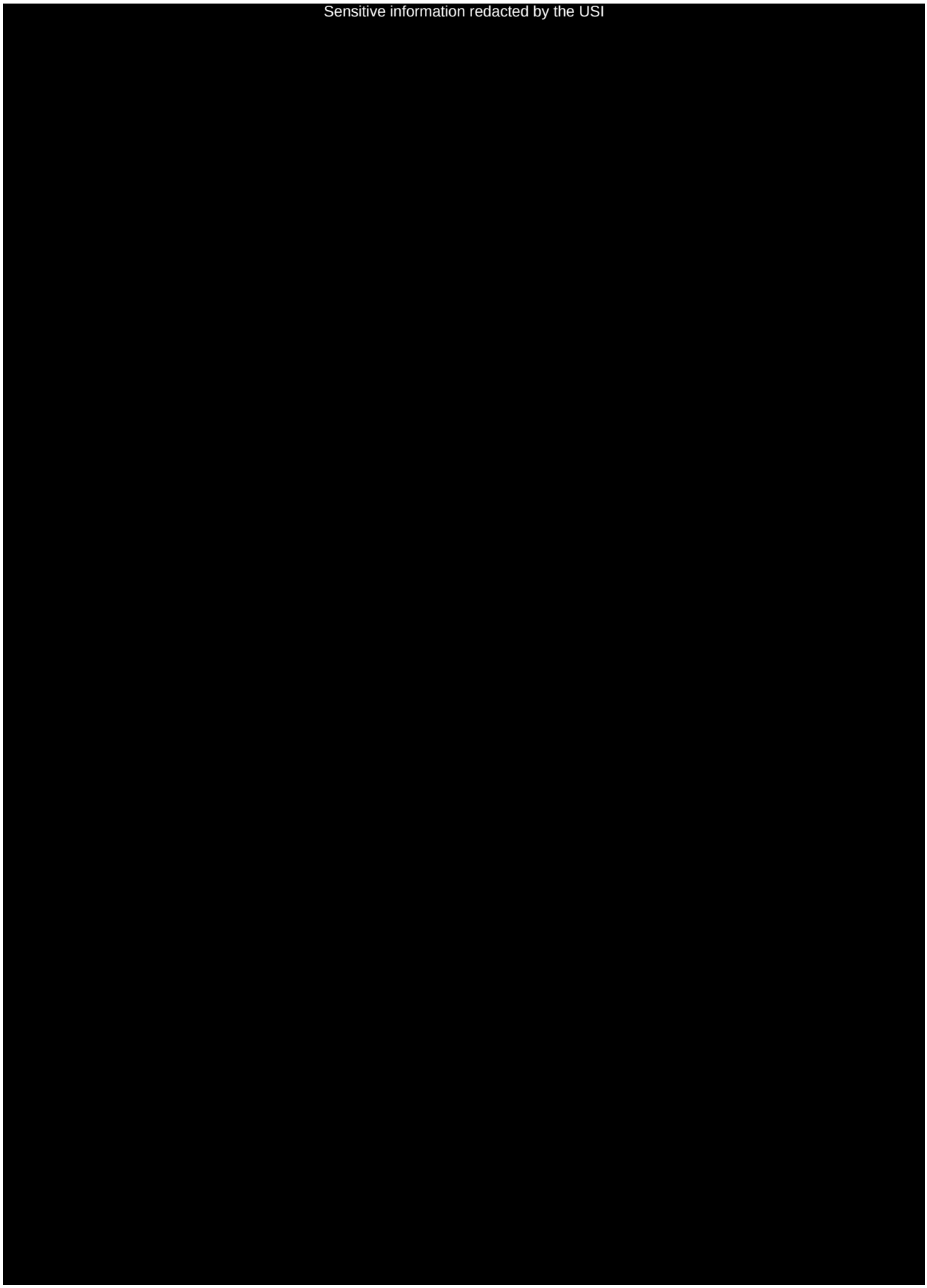

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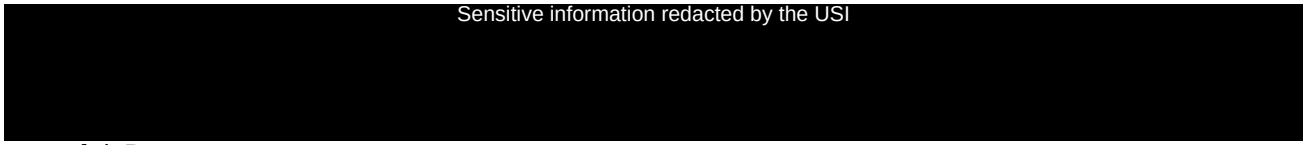

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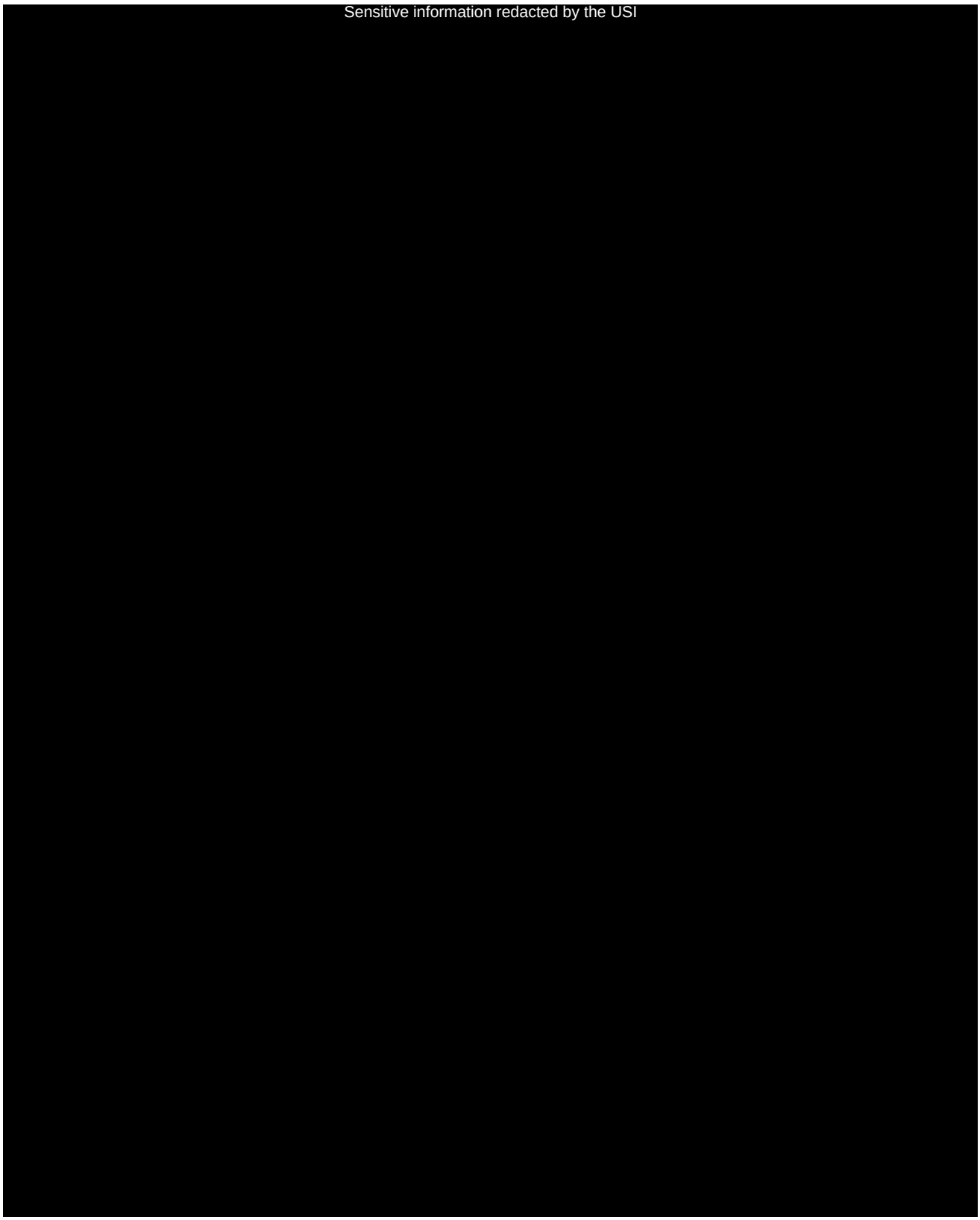

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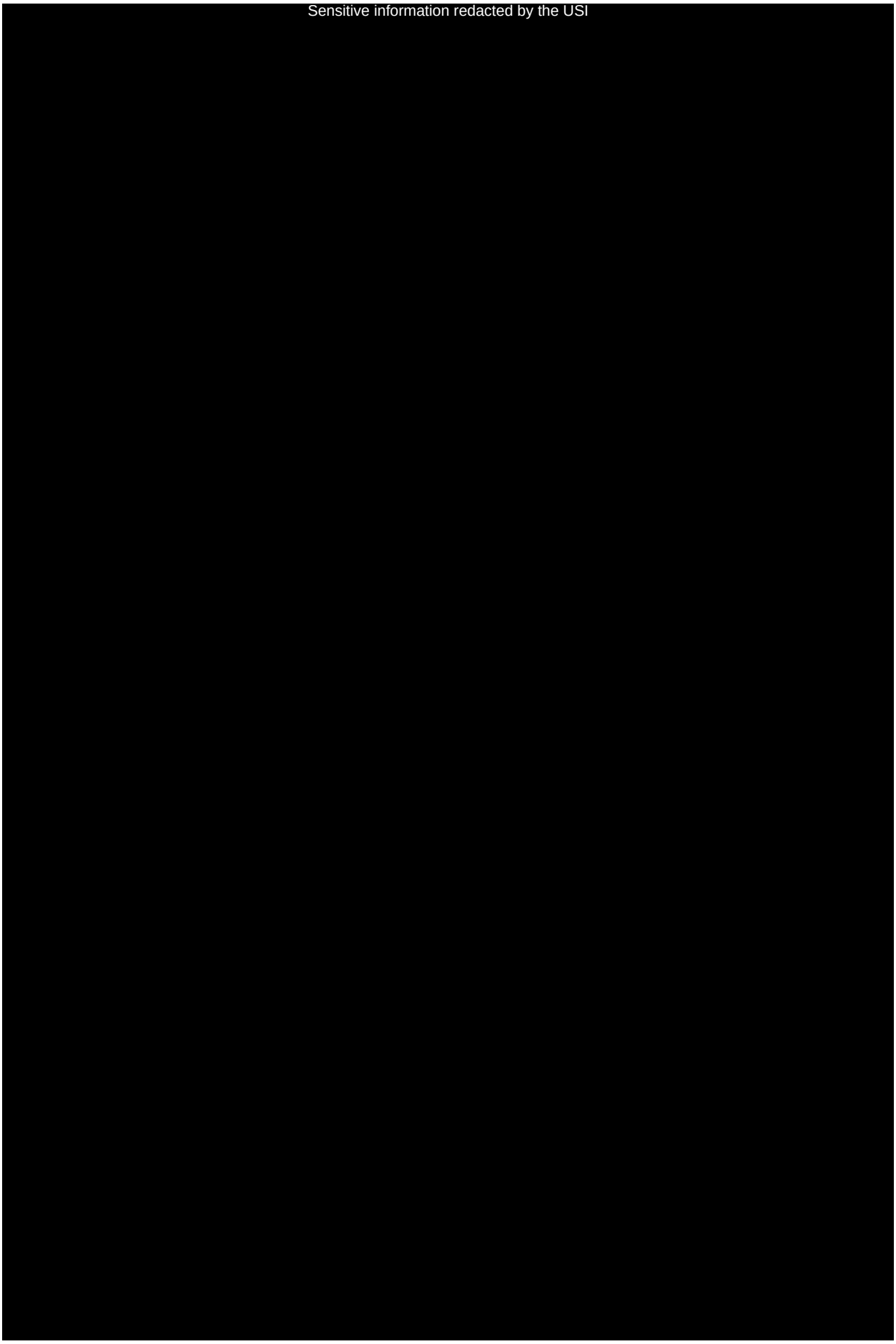

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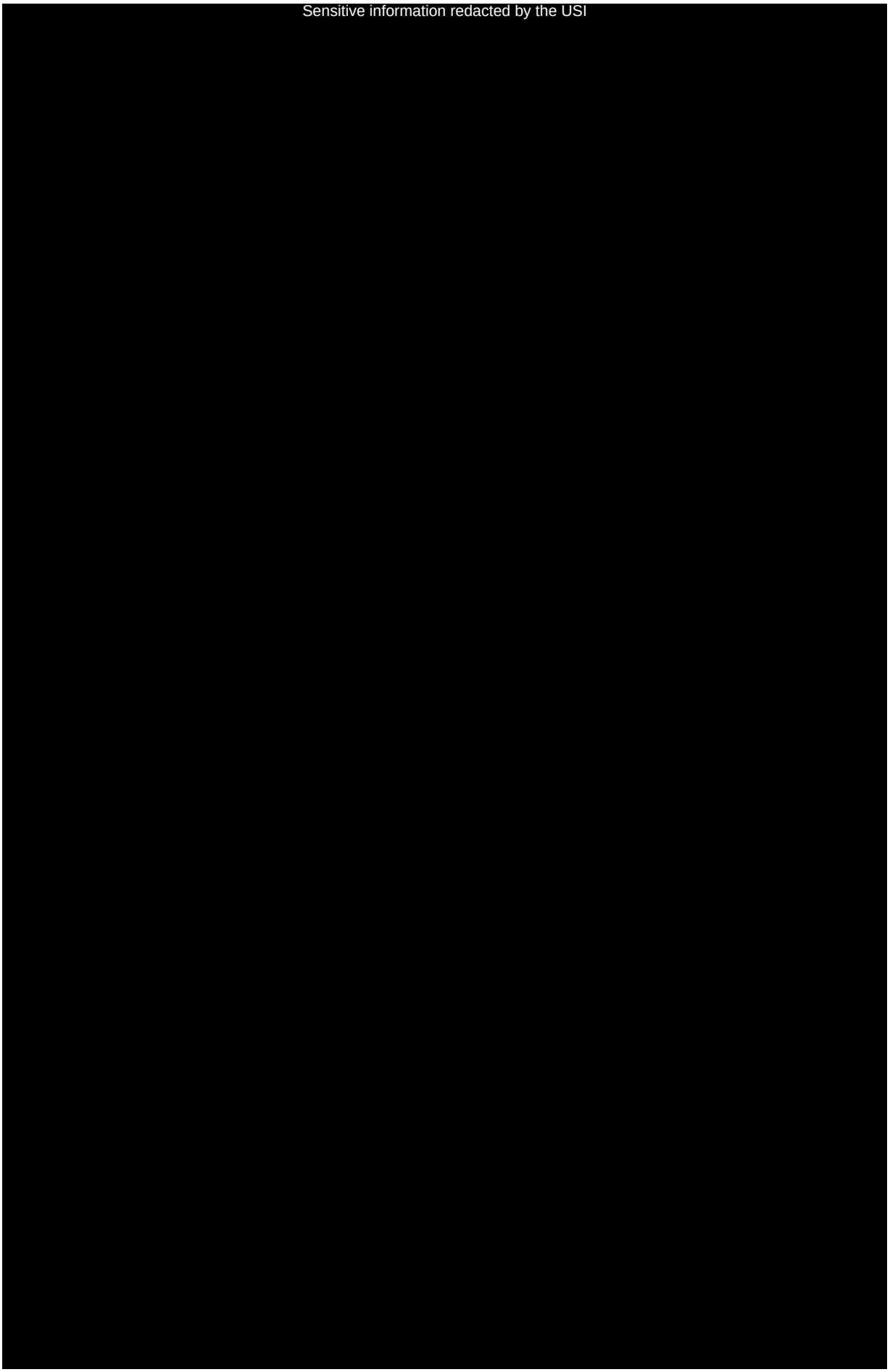

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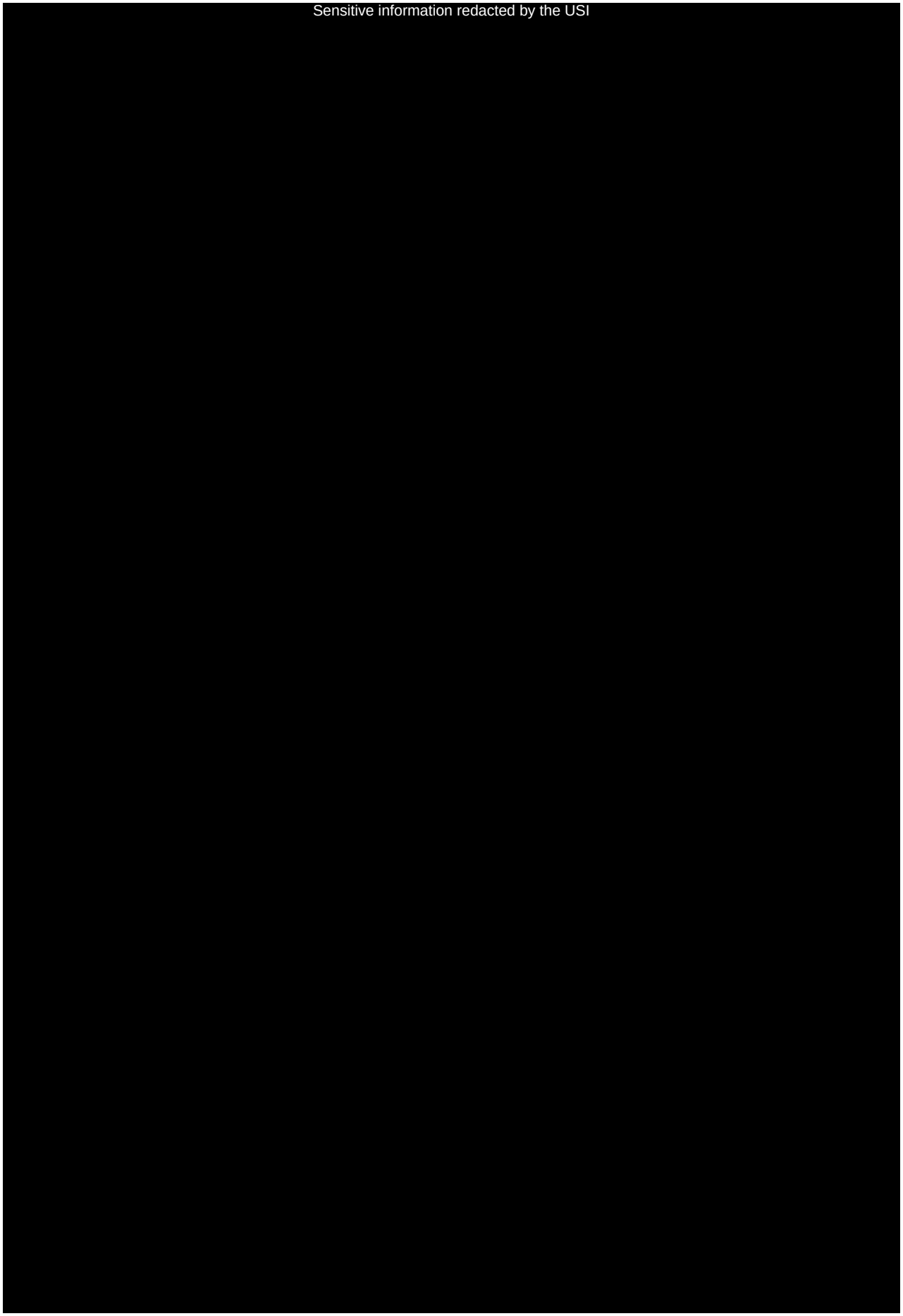

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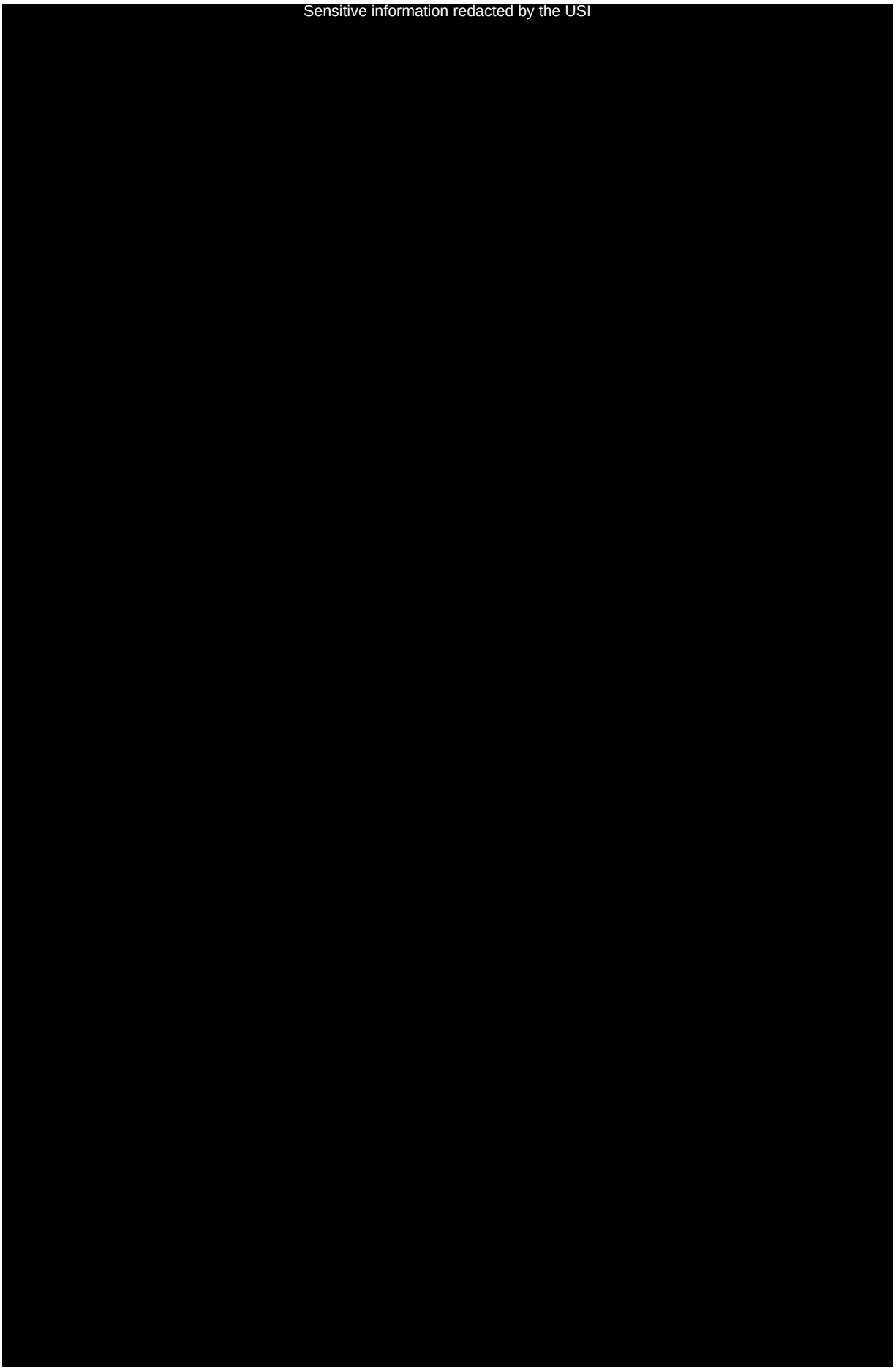

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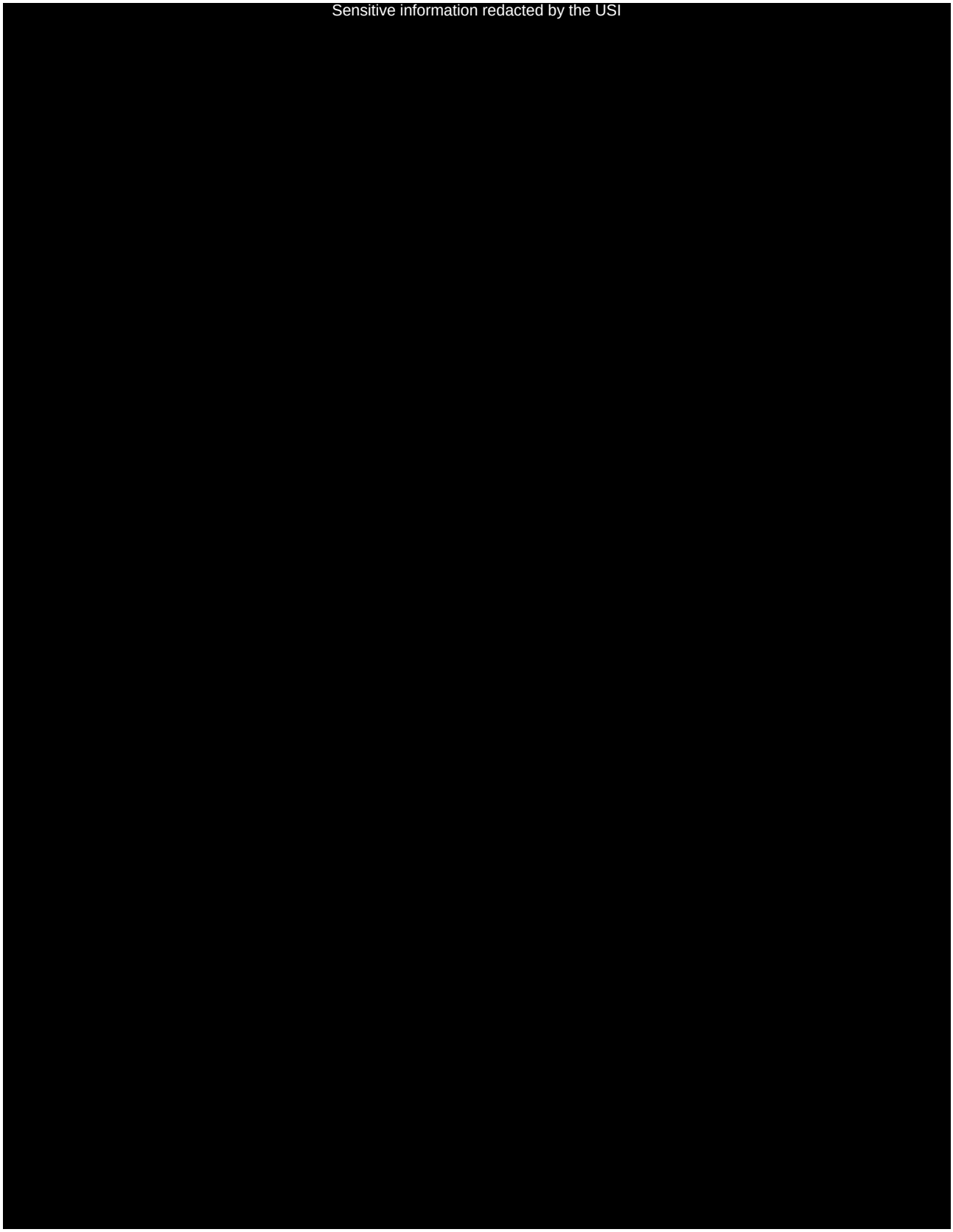

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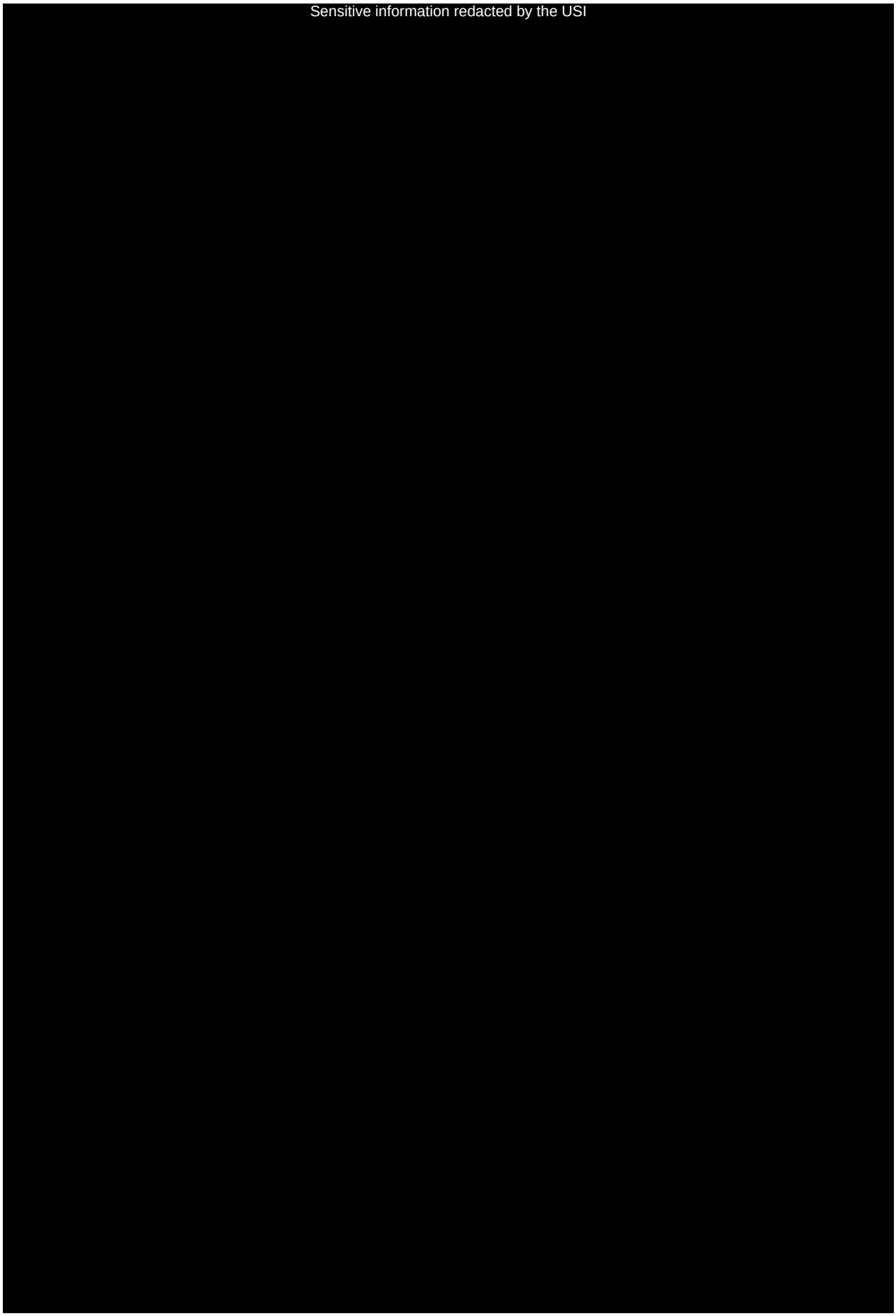

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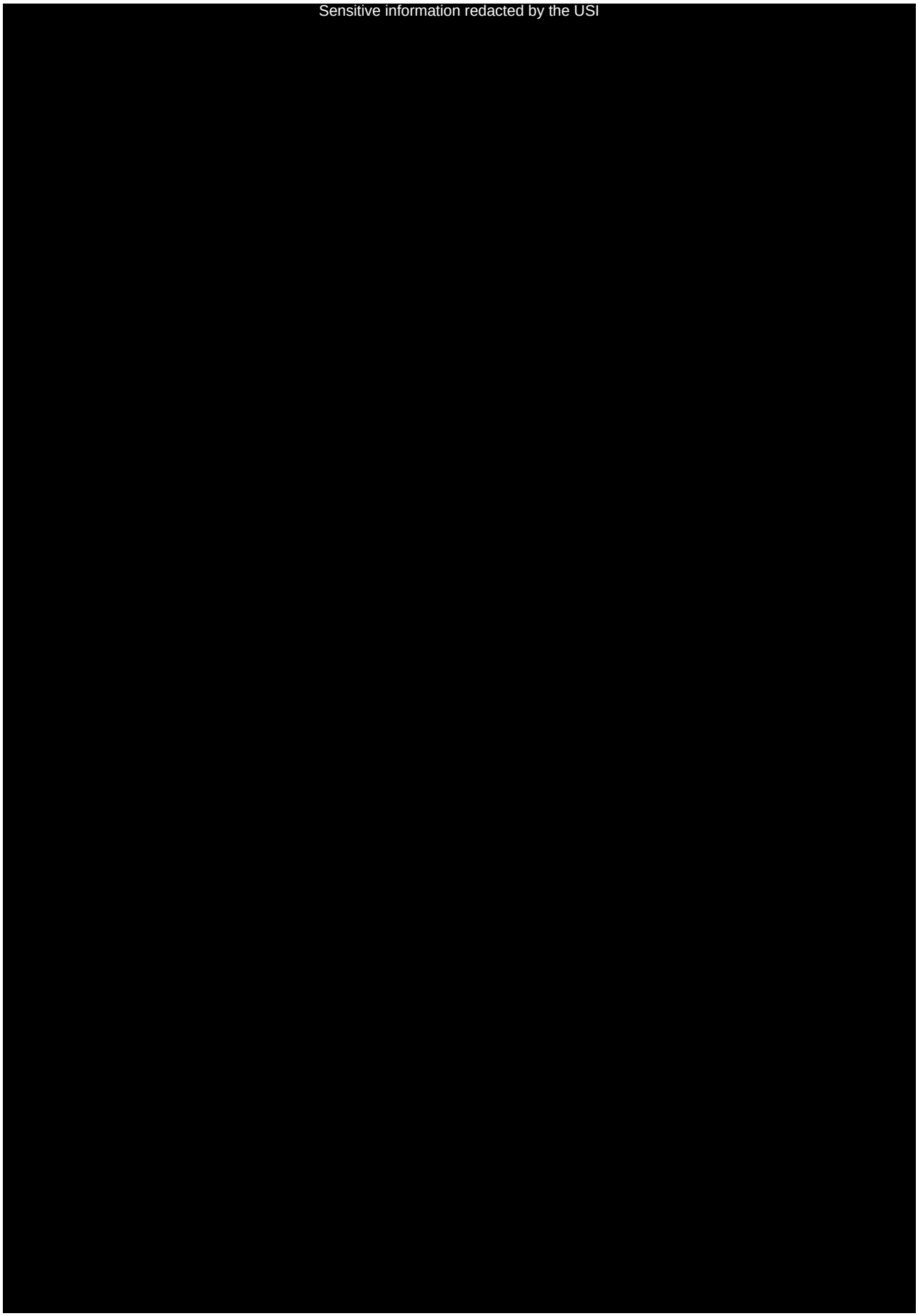

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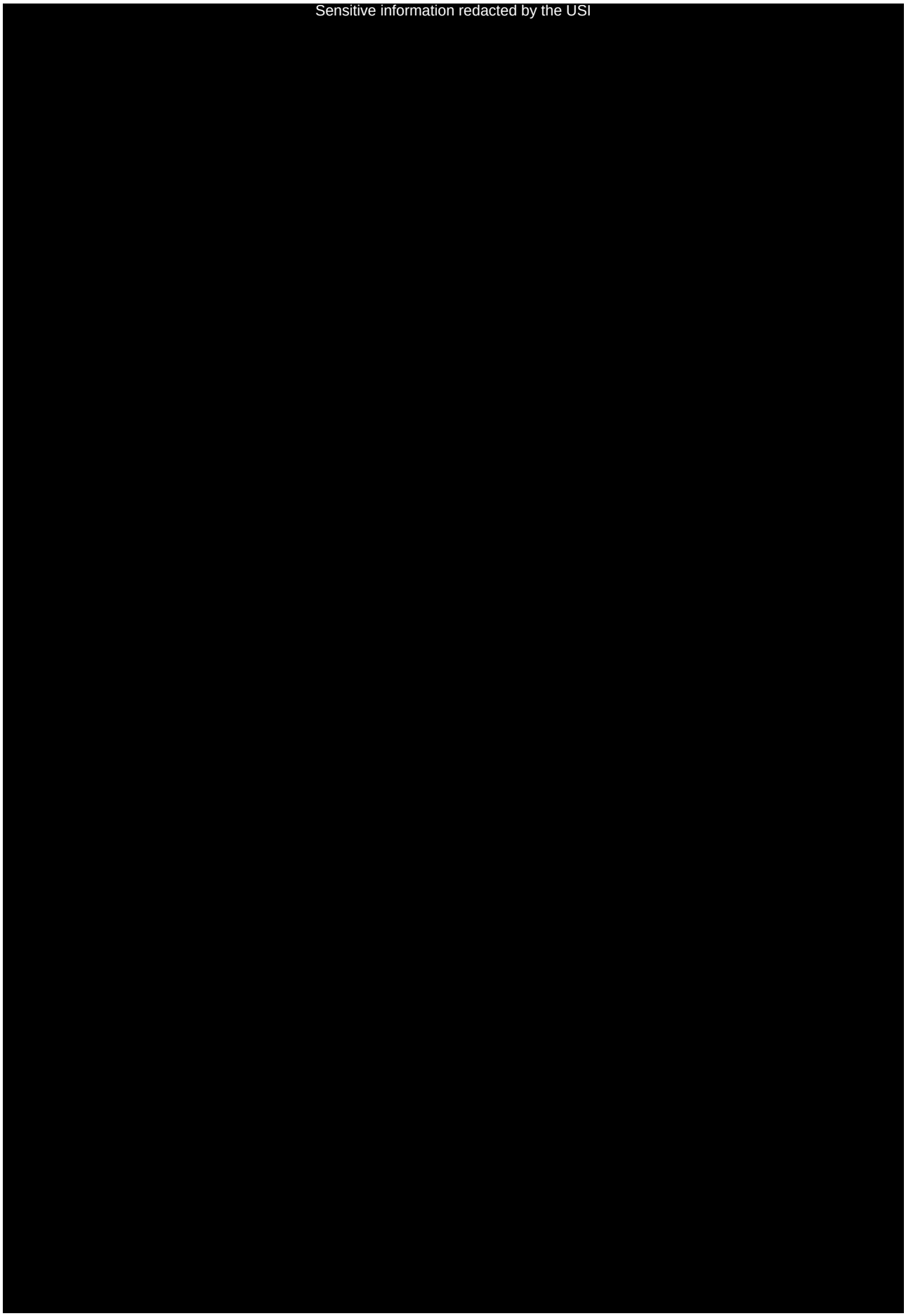

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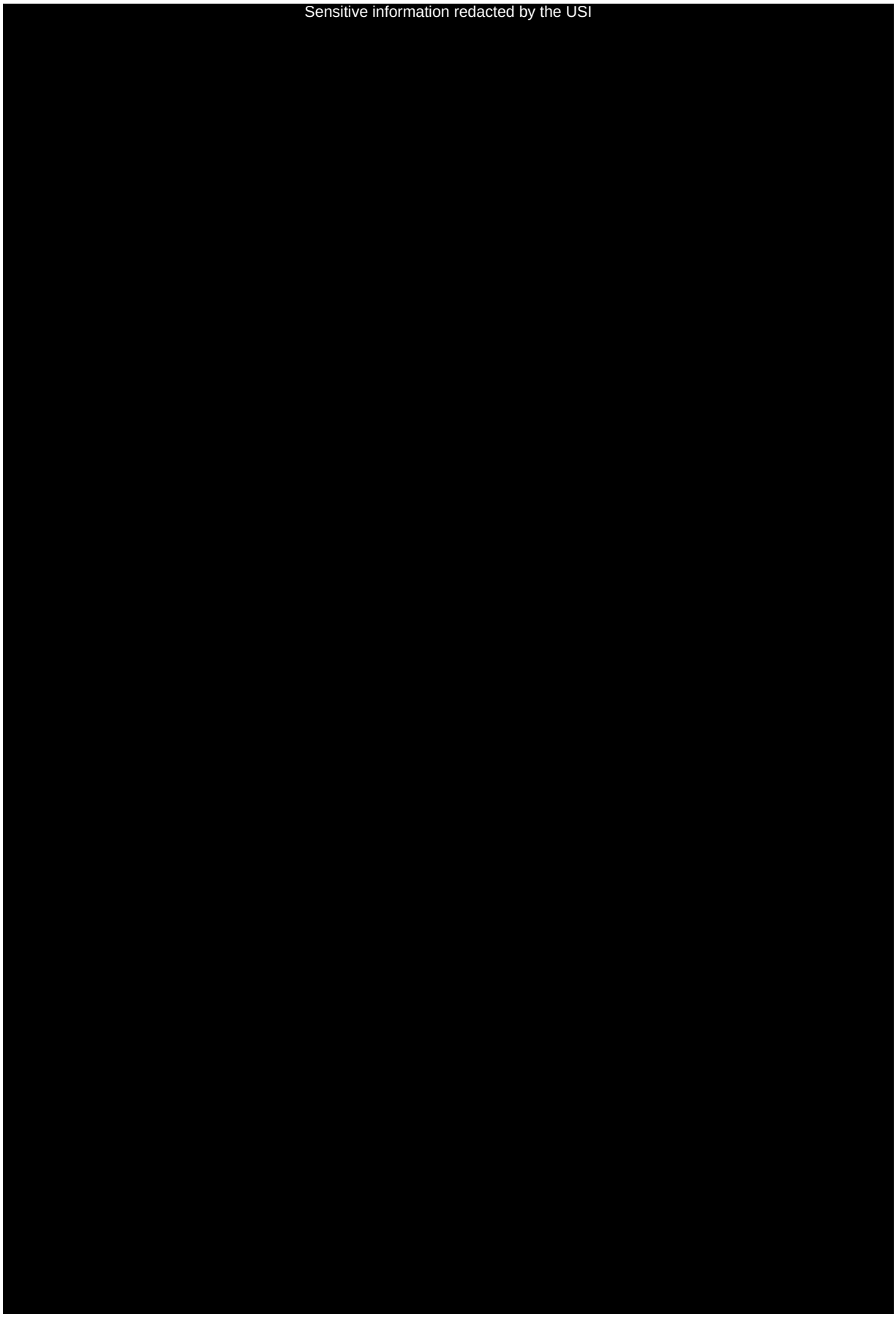

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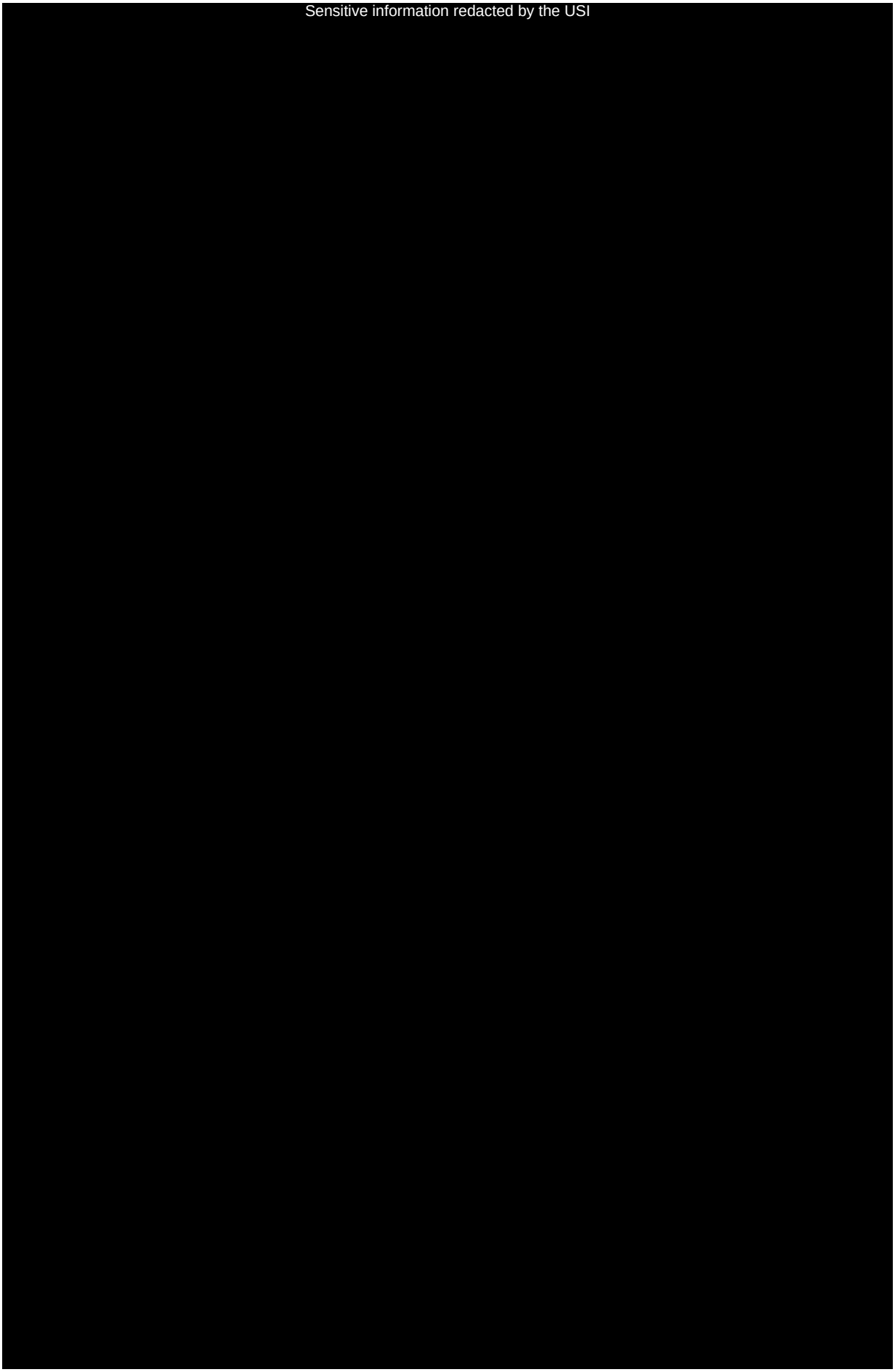

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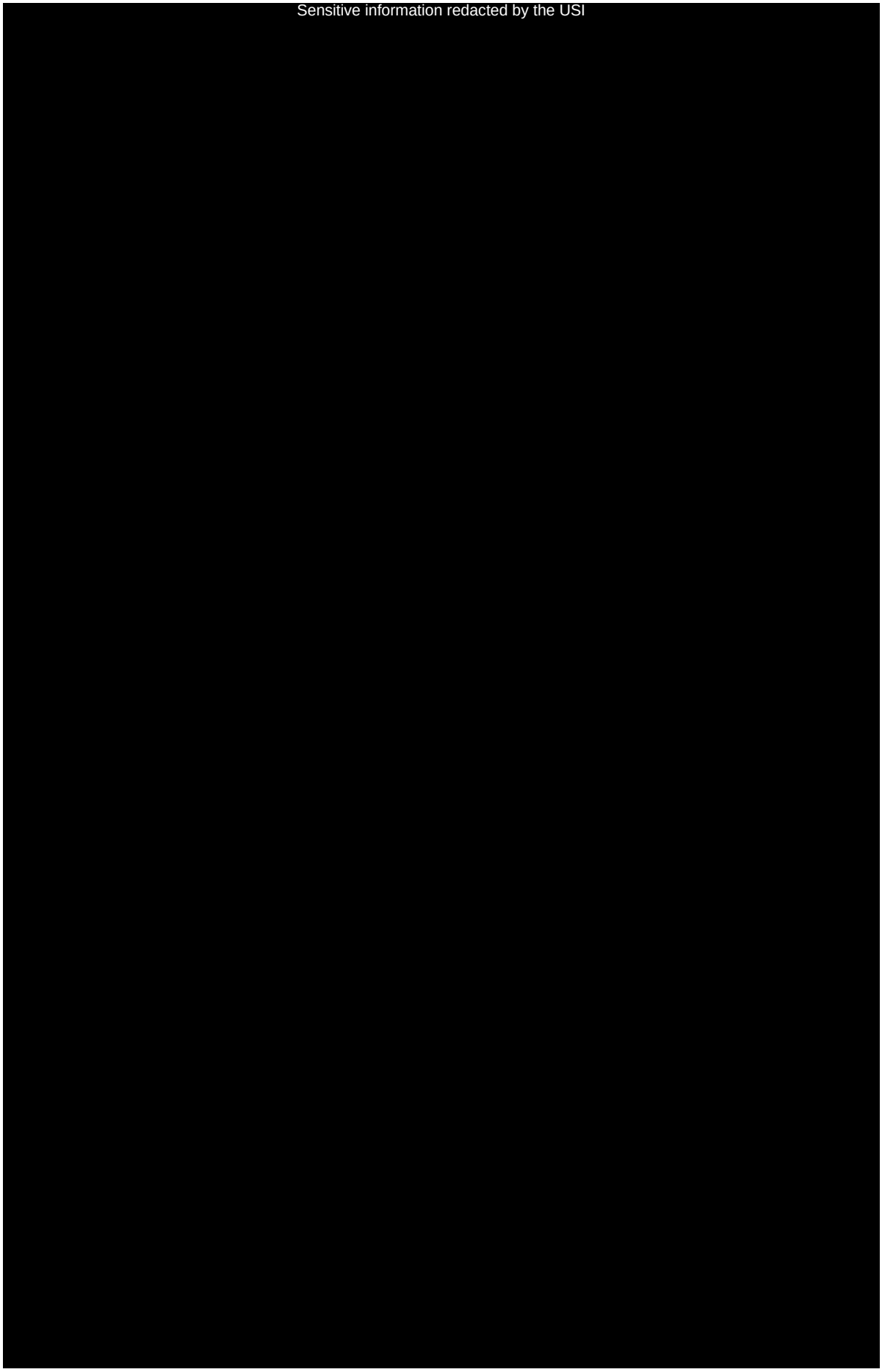

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