Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust

WITNESS STATEMENT OF STEVE EVANS

I, **STEVE EVANS** will say as follows:-

1. I was appointed Consultant Anaesthetist and Director of Critical Care in Coventry (Walsgrave Hospital, now University Hospitals Coventry & Warwickshire) in 1987. I became a Clinical Director in 1994 and subsequently took on a number of senior management roles before moving to the Shrewsbury and Telford Hospital NHS Trust in 2006 as full time Executive Medical Director. I then worked for the Practitioner Performance Advice (PPA) service (then NCAS) as a full-time adviser between 2011 and 2015, before taking on the role of Executive Medical Director of Aintree University Hospital Foundation Trust in Liverpool. I returned to the PPA service as Senior Adviser (Secondary Care) in January 2018. I have been involved with the Belfast Health and Social Care Trust in Northern Ireland for about 18 months which follows my providing advice to the Trust in relation to the Inquiry into hyponatraemia-related deaths and the departures of Grainne Lynn and Colin Fitzpatrick from the organisation. At this stage I took on the senior adviser role for Northern Ireland. My former colleague, Steve Boyle continued to oversee the Southern Health and Social Care Trust but following Steve's retirement earlier this year I took up the post of Lead Adviser for the whole of Northern Ireland (from April 2022).

2. Also by way of background, I am a past chairman of the British Medical Association's (BMA's) Medical Managers' Subcommittee. I also served three terms on the Board of The British Association of Medical Managers (BAMM) and was a member of the Medical Leaders' Professional Council. I have been a member of the Professional Standards Committee of the Royal College of Obstetricians and Gynaecologists and an external adviser on appointments committees for Local Health Board Medical Director posts for NHS Wales.

3. I make this statement to address some wider topics raised by the Inquiry. I have had no historical involvement with the case of Mr Aiden O'Brien - the case was dealt with by former colleagues who have provided statements.

4. I am able to comment generally on PPA currently as an organisation, our interactions with various Trusts and the challenges we face in practice which can reduce the effectiveness of the implementation of the MHPS ('Maintaining High Professional Standards in the Modern HPSS') framework. In particular my work means that I have day to day experience of working under the Northern Irish MHPS Framework.

Challenges in practice

5. The MHPS framework in Northern Ireland is slightly different to the framework used in England. Although the documents are similar, there are some notable differences. In the Northern Ireland version some of the anomalies in the English version have been removed and there is a greater emphasis on preliminary enquiries. Whilst I think this emphasis can be helpful in avoiding unnecessary formal action, there is a risk that some cases may be 'left in limbo' for too long during preliminary enquiries - there are no timescales set out in MHPS for this stage, during which the practitioner has few rights/protections.

6. Generally I would say that those who have to use the MHPS (in Northern Ireland or England) are comfortable with the current version. It has some flaws but most of these have been addressed in case law, which has provided clarity on some issues.

7. I would agree with Colin Fitzpatrick's statement that the real issues are not with MHPS itself, but with the way it is put into practice, and there are a number of reasons that I and others at PPA have observed in our more than twenty years of providing advice and dealing with performance concerns that mean this is not always done well.

8. We are an advisory service and of, course, can only act on the information provided to us. We cannot compel Trusts to work with us or direct them to take certain steps or achieve certain milestones under MHPS.

9. One of the biggest issues we see in these types of cases is the lack of organisational and corporate memory. Due to the nature of the work, there can be a high turnover of Chief Executives and Medical Directors within Trusts. It follows that senior personnel are often not based at a Trust long enough in order to fully grasp any pattern of emerging issues that might inform the wider picture about a practitioner. This lack of corporate memory also impacts on both the continuity of the handling of the case and subsequent communication.

10. A linked concern is that in many Trusts there is a lack of any central repository or coming together to join the dots on what might cursorily appear to be low level concerns. If concerns are not generating actual complaints it is often unclear how and whether they should be captured. Some complaints will be dealt with by a complaints service such as PALS and this information sometimes then just sits in that silo. In my view it is important for a Trust to think about how this type of information is triangulated and discussed so that core operations groups are appropriately sighted on possible emerging issues. We do not know whether this is something that might have provided different or additional information in Dr O'Brien's case.

11. Another systematic issue is lack of resourcing. Where there are a significant number of issues with a particular medical workforce within a Trust, there needs to be enough time to commit to addressing those issues and, by and large, many senior personnel do not have this. They are trying to manage the concern using the most appropriate procedural pathway, taking a proportionate and reasonable approach with the practitioner, alongside the many other demands of their day job. The resourcing to follow MHPS in a timely way is therefore not always in place. There has to be a commitment within a Trust to address any resourcing issues, which is not necessarily always there, from my experience.

12. In order to strengthen the application of the framework, following any discussions I have with Trusts, before the end of the call, I organise when and how the next review discussion will take place and put this into our respective diaries. This method works well for me as it ensures that the Trust contact (usually the Medical Director) knows when we will be speaking again to discuss progress. This can help keep cases on track and makes it less likely a case will drop off the radar.

13. We also established a system in 2022 whereby if an adviser is closing a case due to lack of response from a Trust, we write to that Trust, highlighting the issues that have been shared with us and reiterating and explaining any further information we have been seeking from them. If there are remaining concerns but we have effectively reached a dead end due to lack of response, we then consider contacting the Chief Executive Officer or the Medical Director of that Trust to set out that there have been strenuous attempts to discuss a case and that we, as an organisation, have been unable to do so.

14. One further difficulty perhaps is that the MHPS Framework does not really cater for sizeable issues (as this case became). Matters tend to become more complicated where the circumstances lead a Trust to conclude there needs to be a "lookback" or "deeper dive" into cases. I understand that in Mr O'Brien's case information kept being added to the Trust's understanding of the situation.

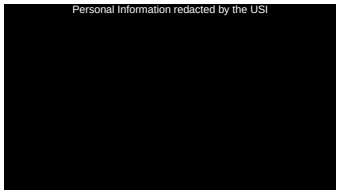
15. On the issue of expanding investigations, on 1 June 2022, NHS England published the National Quality Board: Recall Framework exhibited at [SE1]. The National Quality Board Recall Framework contains principles for conducting a patient recall in the interests of safety for providers of secondary care. It includes key elements which should be considered in order to conduct a recall process which is rigorous and patient-centred. Although this is for use in secondary care, the principles outlined may also be useful for recalls taking place in other settings. This Guidance is expected to help Trusts manage these types of issue.

16. I am aware that in Mr O'Brien's case he was in touch with the PPA directly and I was asked, in the context of the Inquiry, to consider how contact with a practitioner can impact on a case. We always encourage organisations to be open and transparent with us and ask them to also share our involvement and correspondence with the practitioner. Equally, should a practitioner contact us directly, we request that any correspondence with them is shared with the organisation. We hope that by doing this we can increase transparency and openness between the parties and reduce or remove conflict, as all involved are then aware of what we are being told and any advice we are giving. For reasons of confidentiality we do not share correspondence with the other party directly. We work with all parties including organisations and representative bodies to foster open and constructive dialogue. The dialogue and the way we work with practitioners is set out in our publication 'Practitioner Performance Advice: Guide for healthcare practitioners', which is available on our website at: https://resolution.nhs.uk/services/practitioner-performance-advice/advice/information-for-healthcare-practitioners/ . The support and advice we offer is not only for organisations. When practitioners are in touch it can afford us a well-rounded narrative.

17. Although it may not have been so at the time, a case such as Mr O'Brien's would certainly now have been escalated internally as a case to note. In recent times the case to note mechanism has been strengthened to include cases which have particular features – such as patients having come to harm or where the case is 'high profile' and likely to cause media attention. Although NHS Resolution's Senior Management Team would not necessarily need to be sighted, the Core Operational Group (COG) would be. The current COG consists of Vicky Voller (Director of Advice and Appeals), Karen Wadman (Lead Adviser), Sanjay Sekhri (Deputy Director of Advice and Appeals), Dr Alison Budd (Specialist Adviser) Dr Sally Pearson (Responsible Officer) and Dr Rineke Schram (Lead Assessment and Remediation Adviser).

Statement of Truth

I believe the facts stated in this witness statement are true

Signed 

Dated 12 July 2022

National Quality Board

National Patient Recall Framework

Purpose

1. The overall objective of a patient recall is to limit or mitigate the harm to patients and provide a clear focus for their ongoing care. Patient safety is the priority concern for all recall processes.

2. The purpose of the national recall framework is to provide guidance on the arrangement of a recall of patients. This guidance is for patients who need to be called back by a healthcare provider for further consultation, review and/or clinical management because a potential or actual problem has been identified. There is a need to:
   - understand if and how patients may have been affected and/or
   - provide any further information, treatment and support needed.

Guiding principles

3. The patients' needs must always be placed at the centre of a recall process and their voice should always be heard. The following are guiding principles for how to conduct a patient recall:

   - Patient safety should be the main priority
   - There should be appropriate and compassionate engagement with patients to ensure that the process remains patient-focused
   - The patient recall should be carried out in a collaborative and engaging manner to ensure openness and transparency as well as safeguarding sensitive information
   - There should be an objective and expert-led clinical review of patient care, to identify impact and harm to patients, followed by appropriate investigation and treatment as a result of that review
   - There should be compliance with values, policies and procedures which foster good practice
   - There should be fair and just engagement with healthcare practitioners and colleagues
   - Patients should receive an acknowledgement and explanation of what the concerns are
   - There should be a willing offer of an apology where warranted or appropriate in an open and transparent manner to support better relationships going forward
   - Patients should be made aware of the organisation's complaints process in appropriate cases

- There should be professional, respectful and timely engagement with other key stakeholders (e.g. regulators, other healthcare providers) with a default to share relevant information where this is possible
- There should be a focus to identify learning that can inform practice and continuous improvement (note this is not the primary purpose)
- Variation in how recalls are conducted is likely to exacerbate and perpetuate pre-existing health inequalities. We expect the introduction of this framework to provide clarity and drive consistency, reducing unwarranted variation, and ensuring patient's individual needs are at the centre of the decision making process.

Scope of patient inclusion and exclusion criteria

4. There should be a robust process for identifying which patients are in and out of scope for the patient recall. This should be evidence-based where possible. Flexibility may be required in amending the criteria if new information comes to light.

5. There are a number of factors to consider when prioritising patients, including the impact of involving patients in review and the potential harm that may cause.

6. It can be potentially stressful for a patient when they are recalled for a review of their care or treatment, therefore ensuring that you do not include patients unnecessarily is important. Each patient experience will be unique and must be reviewed with patient safety as the priority concern.

7. If the patient recall started through another organisation, the agreed inclusion and exclusion criteria should align as much as possible. A main contact must be nominated by the lead organisation before contacting the patient.

Patient engagement

8. As set out in the guiding principles, the recall must be patient-centred and must uphold the principles of honesty, openness and transparency.

9. The recall must recognise the right of the patient to make decisions about their own care, with appropriate space, time and information which should be maintained throughout the recall process.

10. The recall process must seek approval from the patient on whether they would want their family, carer or loved ones to be involved. If so, their wellbeing and the impact on them should also be considered.

11. Patients who do not want to participate in the recall should be provided contact details, should they change their minds at a future point.

12. Patients should have support with transport, accessibility and language needs where necessary. Patients should be provided with access to emotional and psychological support where necessary.

13. Patients must receive frequent communication throughout the recall process with a specific and named contact. The patient's GP must also be kept informed of discussions and ongoing investigations.

Patient recall team resources

14. The recall process requires a skilled and competent team who clearly understand their roles and responsibilities. For example, this should include the informatics team, who identify all the patients to be considered in the recall, and the team of clinicians required for the review of patient care.

15. An executive director, or person of equivalent seniority within the organisation's governance, must be identified as sponsor of the recall process. This sponsor must appoint a named individual who is then responsible for the operational delivery of the recall process.

16. Staff members must be provided appropriate briefing ahead of initiating the recall. Adequate pastoral support should be provided to all staff members involved in both the incident and recall process.

17. All members of the team must have the skills and competencies to effectively support patients, who may be anxious during the recall process.

18. Adequate financial resource should be agreed before beginning the recall to ensure it is managed in a timely fashion.

19. Ensuring adequate resource for conducting the recall should include the identification of backfill/overtime for staff who are involved in the recall and are doing so on top of their full-time job to provide the time needed for this task.

Patient review process

20. No matter how the patient was treated, including NHS patients receiving care in the independent sector, all patients should be treated equally in the recall process and their care should be individualised to each patient's need.

21. Recall of activity should be undertaken by the provider of care in which the incident occurred unless there is a compelling reason why it cannot. There should be timely and co-operative agreement between providers, with documented evidence that those discussions happened.

22. The protocol for conducting the review of patients, and the clinical care pathway if required, should be clearly documented to ensure all steps are carried out consistently across the patient cohort. This should be reviewed as part of an ongoing learning process.

23. Providers should commence a timeline record to track the overall recall process as soon as the patient recall begins. It is advisable for both patients and providers to have a clear audit trail which is regularly updated.

24. The potential for media attention should be considered and providers should take care to issue clear communication to ensure reporting is accurate and does not cause additional stress or harm to those impacted.

25. Providers should consider the possibility that claims and eventually litigation may arise out of any recall. Organisations should therefore ensure that their in-house legal team is involved from the outset and, where appropriate, should advise patients where they can obtain support. Guidance will be available from NHS Resolution to its scheme members, or from other relevant bodies, on the management of such claims.

26. The statutory 'Duty of Candour' found in regulation 20 of SI 2014/2936 requires providers of health and adult social care services (regulated by the Care Quality Commission) to be open with patients when things go wrong. It must be followed as applicable by health care providers and other registered persons. Emotional support, empathy and respect should also be provided where necessary as part of a patient-centred recall process.

27. In putting together the recall process, providers should consider best practice and lessons learned from across the system. Subject always to the requirements of the statutory duty of candour the following are suggested steps to take for a patient recall process:

- Patients should be made aware that they are being recalled as soon as the healthcare organisation is in a position to do so. Once the recall processes are set up to support them, with reasons for the recall agreed, they should receive an apology where appropriate and be told of the likely steps that will be taken. Patients must also be able to share their experiences and ask questions.

- Following the initial assessments, patients should receive individualised plans for their further care, which should be documented. Processes should also be in place to ensure these plans are followed.

- A patient-tracking database should be initiated to track and monitor progress of the delivery of the patient recall. This database should include demographic details of the patients and information on their planned pathway. A member of the recall team should be given responsibility to update and oversee the patient-tracking database. If a recall is happening across multiple providers, this tracker should be shared with the relevant teams, subject to compliance with satisfactory safeguards in accordance with the Data Protection Act 2018 and UK GDPR – Art 9(2)(h) and (3).

- Reviews and assessment should reflect the standard practice at the time in which care and treatment were originally undertaken.

- At the end of the consultation, the patient should be updated directly with a written letter in simple language, outlining the details of the consultation and the next steps. Contact details for further information can also be provided.

Learning for continuous improvement

28. While the process of learning and improvement should be carried out as a separate process to the recall, it should follow immediately from it and be informed by what is found through the recall process.

29. There must be recognition that delivery of any effective change and sustainable improvements require continuing commitment. A mechanism for how any recommendations and quality improvement can be delivered and monitored should be agreed.

30. The process of learning following a recall process should include consideration of how the recall itself was conducted and feedback from the patients who were involved, to identify ways in which improvements could be made to future recalls.

31. A final report is recommended to provide a summary of the findings and recommendations for continuing improvement. This report should be open and transparent in its findings and available to patients and the public.

The National Quality Board (NQB) champions the importance of quality and drives system alignment across health and care on behalf of the national bodies. The organisations represented on the NQB are: NHS England and NHS Improvement, Care Quality Commission, Health Education England, NHS Digital, National Institute for Health and Care Excellence, Department of Health and Social Care, Office for Health Improvement and Disparities, UK Health and Security Agency and Healthwatch England.