significance of it was lost a bit. But also I think what we weren't good at was the system was joining up all the dots and recognising that triangulation was a really important aspect of this. We needed to put out all the aspects at the same time. But also that we were sensitive enough to what the smoke signals were in the system in terms of how we thought about the system. 12:33

183 Q. Would you have expected data to be interrogated robustly before it reached you --

A. Yes. 12:33

184 Q. -- so your default position would be to rely on it?

A. Yes.

185 Q. Whose role would that be?

A. That should have come up through the Operational and Professional Governance lines. Again, in relation to appraisal revalidation data, complaints, all of that, in relation to any of the clinical outcomes or any of the information that was shared in relation to the data about dictation, all of those kind of things. I was working on the assumption that we had been over this so many times that what I was given was robust. 12:33 12:33

186 Q. I can't remember the name of the witness just at the moment, someone gave an example of there being eight letters up for dictation and three of them are done, it could be that those three letters are for one patient. 12:34

A. Yes.

187 Q. As a very simple example, that shows a straightforward piece of data actually can completely misrepresent the true backlog in a situation like that?

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

Received from Charles McAllister on 09/06/22. Annotated by the Urology Services Inquiry.

19. Issues around timely surgical reviews of referrals/daily consultant reviews/DNAR discussions.
20. M&M meeting dysfunctional.
21. JOB PLANS

That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

I'd be interested in your thoughts.

Charlie

Received from Charles McAllister on 09/06/22. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

I'd be interested in your thoughts.

Charlie

4.6 I received the following reply (9th May 2016, 15:47) from Dr Richard Wright, Medical Director (*S21 No 32 of 2022 Attachments, 20160509 email re problems from RW*);

From: Wright, Richard [redacted]
Sent: 09 May 2016 15:47
To: McAllister, Charlie [redacted]
Subject: Re: Problems

That seems a fairly accurate summing up. can't all be fixed in a day. Should we have a get together to work up an action plan? regards Richard

Sent from my iPad

4.7 And the following reply (9th May 2016 at 22:37) (S21 No 32 of 2022 Attachments, 2. 20160509 email re problems from RC) from Ronan Carroll Assistant Director Acute Services:

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie [redacted]
Subject: RE: Problems
Importance: High

I think it is safe to say you have a good handle on things

Ronan

Ronan Carroll

Assistant Director Acute Services

ATICs/Surgery & Elective Care

329 Q. With who? Sorry?
A. Dr. Wright.
330 Q. Again on raising that, did Dr. Wright take any action?
A. Not that I remember.
331 Q. Having raised this quite substantial list of issues, what action did you take to set about addressing points 1 to 21 of that email? 14:40
A. Some of them were not possible for me to address on my own. Some of them required the help of a CD. The issues -- well, there wasn't a lot I could do. I said about planning the issues around urology, which were certainly in the forefront. 14:40
332 Q. I think we'll return, perhaps, in due course to the specific issues about urology in the course of this afternoon. During your time as Associate Medical Director, you ultimately leave that role in October '16, were you any less concerned about this list of issues at the time you left your role as whenever you started? 14:41
A. No, I thought it was inevitable there was going to be problems in the future. 14:41
333 Q. Just so I'm clear, as an experienced Associate Medical Director these aren't the type of issues you might expect to come across in a division or in a part of the Trust i.e. Surgery, this is something over and beyond what you might have expected to see whenever you came into the role? 14:41
A. Well, I heard Mr. Mackle say that this was -- he would expect us to be fairly normal for a GTH and a lot of

45.3 I was not concerned that governance issues were not being identified and, on reflection, I believe the processes *did* identify the areas of concern relating to Mr O'Brien prior to 2020. However, the important link between each individual issue and the risk of wider issues within his practice was not made. The system and processes failed in that the various patterns of behavior of Mr O'Brien were not adequately addressed over many years. This may have been a failing of the system (including the people who were part of it / upon whom it relied) but I also believe it was significantly contributed to by Mr O'Brien's response and circle of influence (see further my response to Q74). When I commenced work in the Southern Trust, many of Mr O'Brien's working behavior patterns were widely recognised and simply accepted as 'his way' of doing things.

46. ~~41.~~ **How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.**

46.1 I have not been able to review all Trust governance documents covering my employment in Southern Trust from May 2014 onwards to reflect on how concerns raised by me or others are reflected in them. However, as stated in previous answers, I have reviewed the Risk Registers and believe these do not adequately reflect the level and potential severity of patient risk related to the mismatch between capacity and demand.

46.2 Where I raised concerns specifically with regards to Mr O'Brien, I did not receive feedback as to how these concerns had been investigated or addressed. For example, I completed an IR1 in October 2015 (Mr Patient 102) regarding the absence of paper clinical notes and the absence of dictated letters following outpatient consultation. I remain unaware of how this concern was investigated, and if any action was undertaken to attempt to resolve this issue. This is the case for all IR1 / SAI processes with no feedback provided to the reporter, and no opportunity for the reporter to review or comment on

Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

subsequent reports or recommendations. I believe this contributed to the failure of the Trust systems to adequately identify and address concerns relating to Mr O'Brien.

46.3 I am of the view that, while SAI/SEA investigations and reports may identify individual clinician failings within the reports, the subsequent recommendations often do not address any action plan to address these individual failings or monitor subsequent performance. For example, the SEA report regarding Patient 92 identified that Mr O'Brien had not acknowledged or responded to an email alert regarding the CT finding, but the recommendations did not give any recommendation relating to monitoring Mr O'Brien's performance with regards to prompt acknowledgment or action of results. There were subsequently similarities in the individual failings with the SAI regarding Mr Patient 5. Had the Patient 92 SEA progressed quicker (the report was approved in November 2020 – see Q45.2) and had it included recommendations regarding monitoring Mr O'Brien's management of patient results, then the issue may have been resolved and thereby prevented the delay which impacted on Mr Patient 5. *Please see 52. 20210428 Final Report* Irrelevant redacted by the USI *to HSCB 22.4.2021.*

47. ~~42.~~ **What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?**

47.1 As stated in previous responses, patient data collection, specifically with regards to surgical outcomes, has not been adequately collected (in my view) in Northern Ireland, across many specialities, primarily due to the impact of the Health and Social Care (Control of Data Processing) Act (NI) 2016. Additionally, issues in data quality are such that the data that is provided to clinicians for appraisal (CLIP data) is often inaccurate (for example, my personal data regularly does not accurately reflect my case load of renal cancer surgery). As a result, to date, patient data is not adequately sensitive or accurate enough to help identify concerns. Furthermore, CLIP report data is shared with individual clinicians and forms part of their appraisal process but is not shared with

Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

wider. But hindsight is a wonderful thing and where we know this ended up, I think we might have done this differently.

156 Q. I wonder whether it requires hindsight to reach the position which you've just articulated. If I can reflect what Mr. Haynes has said. WIT-53957. He has said: 14:42

"The fact that some aspects of good clinical practice were absent in Mr. O'Brien's working appearance, he feels" -- he does add, "in retrospect ought to have raised concerns that other deficiencies of good practice may also have been present." 14:43

I think we've heard from him in relation to that. I suppose what I'm anxious to understand from you, first of all; having gone through this process and knowing what 2020 revealed, would you, if you were to conduct a similar process again, knowing that this clinician had these four shortcomings, would it be sufficient to stop with those shortcomings or, in future if you were to do it, do you need to look at those shortcomings and see what else they might be indicative of? 14:43

A. Yes. I think if I was doing this again I would cast the net wider, that is based on the experience we've had, and particularly with this case I think that is right. I think it would be helpful if there was more clear guidance around that available to people in my 14:44

As part of the revalidation, we are also aware that the doctors, in every five-year cycle, have to complete an anonymous feedback from our colleagues and an anonymous feedback from the patients. This is the requirement from the revalidation point of view. So, if a doctor who has successfully completed revalidation, he must have had all of these elements. The final year of the revalidation, the final year of appraisal which leads to the revalidation, has in a way enhanced appraisal which has some other elements to that as well. So, revalidation was an important point in time in 2014. Then there is 2015, '16 and '17 appraisals. 12:55 12:55

So, I was a little surprised about having all those and not linking the dots there and finding out what's going on. 12:56

83 Q. I know that this issue comes up again and I'll look at it a little later in the context of the terms of reference. You come back on this issue in a slightly different way. These being your concerns, that the appraisal tool is part and parcel of this debate about Mr. O'Brien and his performance that's going to be formally investigated, did you see to it that these appraisals were brought in to, if you like, the pool of evidence or the pool of issues that had to be considered? 12:56 12:56

A. So as I put it in my statement, before getting to the evidence, I had requested or asked that why should we not involve, or include, the appraisal into the terms

73.5 No mechanism exists to monitor any individual clinician's decision making in outpatients. Issues only come to light when concern is raised by another clinician – be it a GP or a colleague. In Mr O'Brien's case, the ability of GPs or consultant colleagues to identify issues will have been impaired by the absence of letters. Additionally, the workload placed on the consultant urologists by virtue of the capacity:demand mismatch would have impacted on their ability to recognize issues. Single consultant practice also impacts, as for many outpatient conditions only one consultant may see a patient during a long disease natural history.

73.6 The absence of an induction process or handover for incoming AMDs was also a factor. For example, it was only after the identification of the untriaged referrals in 2017 that I was made aware that this had been an issue previously with Mr O'Brien. The resultant lack of continuity within the system resulted in, effectively, a clean slate each time there was a change in the medical management personnel at Clincial Director and Associate Medical Director level.

73.7 Being aware now of the clinical issues, in particular with regard to Mr O'Brien's prostate cancer management, it is in my opinion clear that conformance with external recommendations / guidance was a factor – be they MDM recommendations, NICE Guidelines or other external recommendations. I am told individual oncologists had raised concerns directly with Mr O'Brien regarding his use of low dose bicalutamide but Mr O'Brien did not change his practice. On reflection, other behaviours (such as his continued use of monopolar / glycine for transurethral surgery despite external recommendations) should have alerted others to the likelihood that he was not following other forms of external guidance. I am aware that similar behavior from Mr O'Brien regarding external recommendations was encountered following the 'Improving outcomes guidance' which recommended centralization of specific cancer related surgery within cancer networks. For Urology this covered Cystectomy for bladder cancer, radical prostatectomy for prostate cancer, penile cancer surgery and nephron sparing / IVC thrombectomy surgery for kidney cancer. After cystectomy surgery was centralized to Belfast, despite (I understand) having been told that no further

Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

and overlaps with some of the information provided paragraphs 154-193 of the Permanent Secretary's statement under the section titled *"Mr Aidan O'Brien - Urology Concerns Timeline"*, however in the interests of completeness I have recounted events from my perspective in full.

56. My response will show that:

- the Trust-led Lookback Review was already under way when the Department became aware of concerns relating to urology services in the Southern Trust, after which the Trust's progress with the Lookback Review was guided by ongoing discussion with the Department, HSCB and PHA, both prior to and subsequent to the establishment of a Department-led Urology Oversight Group in October 2020;
- the adoption and development by the Trust of a SCRR process arose following discussions between the Trust and the Royal College of Physicians and subsequent discussion within the Urology Oversight Group;
- the decision to establish a public inquiry arose following the establishment of the Urology Assurance Group and discussion with the Chair of the Independent Neurology Inquiry, with the decision taken by the Health Minister in light of the seriousness and extent of the concerns which were emerging from the ongoing scoping work by the Southern Trust in relation to the practice of Aidan O'Brien, and to ensure that the full extent of the concerns could be identified and pursued in a transparent and independent way.

<u>Early Alert EA 182/20</u>

57. The Department first became aware of the issues relating to potential concerns about patient care and safety relating to Urology Services within the Southern Trust on Friday 31 July 2020, when the Trust notified the Department of an Early Alert on the basis of the Trust potentially needing to contact patients about possible harm.

58. Prior to 31 July 2020 there was no awareness within the Department of concerns relating specifically to Aidan O'Brien or the issues referred to in the Early Alert

Initial call made to CMO Office **(DoH) on** 31.07.2020 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

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

Position: Medical Director | Telephone: [redacted]

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

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

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

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

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

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

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

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) [redacted]

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

Forward pro-forma to the Department at: [redacted] and the HSC Board at: [redacted]

FOR COMPLETION BY DoH:

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

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

Detail of follow-up action (if applicable) ……..……

Received from DOH on 08/12/2021. Annotated by the Urology Services Inquiry

From: Wilson, Ryan (DoH) [redacted]
Sent: 06 August 2020 18:30
To: DoH Private Office
Cc: Pengelly, Richard; Johnston, Jackie (DoH); DoH CMO Office; McArdle, Charlotte; DoH Press Office; Burns, Kim; Jeffrey, Karen; Hardy, Joan; DoH SpAd; McMillan, Alison
Subject: Submission on SHSCT Early Alert - Urology - EA 182/20
Attachments: EA 182 20 - Consultant Urologist restricted from clinical practice - draft sub to Minister.tr5; EA 18220 - Consultant Urologist restricted from clinical practice - draft sub to Minister.DOCX; EA 182 20.pdf

Please see attached for Minister's attention. Further updates likely to follow next week.
Regards
Ryan

Ryan Wilson | Acting Director of Secondary Care | Department of Health
Room D4.19 Castle Buildings | Stormont Estate | BELFAST | BT4 3SQ
[redacted] | Ext [redacted]
[redacted]

From: Hardy, Joan
Sent: 06 August 2020 13:08
To: Wilson, Ryan (DoH) [redacted]
Cc: Greenwood, Victoria [redacted]; McMillan, Alison [redacted]
Subject: Sub on Early Alert - EA 182/20

Ryan

With thanks to Alison, please find attached draft sub to Minister on the EA.

Thanks

Joan

Joan Hardy
Secondary Care Policy and Legislation
Department of Health
Room 19
Annexe 1
Castle Buildings
Stormont
Belfast
BT4 3SQ
Tel [redacted]
Mob [redacted]

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

From: DoH Early Alert
Sent: 31 July 2020 14:09
To: Miller, Preeta [redacted]; Lloyd, Kiera [redacted]>; Wilson, Ryan (DoH) [redacted]
Cc: Barbour, Peter [redacted]; Wilkinson, Chris [redacted]; Galway, Stephen [redacted]; Magee, Joe [redacted]; Hardy, Joan [redacted]; Kirkwood, Conrad [redacted]; Best, David [redacted]; Ruddy, Donna [redacted]; Greenlees, Linda [redacted]; Wilson, David (DoH) [redacted]; Jeffrey, Karen [redacted]; White, Mark [redacted]; Russell, Rodney [redacted]; Burns, Kim [redacted]; Meredith, Karina [redacted]
Subject: Early Alert - EA 182/20

I attach Early Alert (EA 182/20).

As policy/professional lead, please consider whether you need to take any immediate action.

In line with the agreed internal protocol on handling Early Alert notifications, please ensure that any action which you may initiate in response to this alert is copied to [redacted]

If you consider anyone else who needs to be aware of this Early Alert, please let us know.

Safety Strategy Unit
Room D1.

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

FROM: Ryan Wilson
Director of Secondary Care

DATE: 6 August 2020

TO: Robin Swann MLA, Minister

EARLY ALERT (182/20) - CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE

ISSUE:	The Southern HSC Trust has submitted an Early Alert (EA 182/20) about a retired Consultant Urologist, who was restricted from clinical practice pending further investigation regarding approximately 230 patients who may have received sub-optimal care.
TIMING:	Immediate.
PRESENTATIONAL ISSUES	Potential to attract media attention in the event it enters the public domain. DoH Press Office will liaise with colleagues in SHSCT to agree lines. Cleared by Press Office 6/8/20 (TS).
FOI IMPLICATIONS	Consideration should be given to Section 30 – investigations and proceedings conducted by public authorities.
FINANCIAL IMPLICATIONS	None
LEGISLATION IMPLICATIONS	None
SPECIAL ADVISOR COMMENTS:	
RECOMMENDATION:	It is recommended that you note the details in this submission and the following: • **Annex A** – Early Alert notification from Southern HSC Trust; and • **Annex B** – lines to take.

Background

1. An Early Alert was received on 31 July 2020 from the Southern Health and Social Care (HSC) Trust regarding concerns about a Consultant Urologist. A copy of the Early Alert is attached at **Annex A**.

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

2. The Trust also notified the Health and Social Care Board (HSCB) on 31 July 2020, as per the Early Alert protocol.

Issue

3. On 7 June 2020, potential concerns were raised with the Southern HSC Trust about the treatment of surgical patients under the care of a Trust employed Consultant Urologist, who has since retired from Trust employment at the end of June.

4. Given the potential patient safety concerns, the Trust conducted a review of the Consultant's work over a 17 month period to ascertain any wider service impacts. During this process, concerns were identified in: 46 of 147 surgical cases for the insertion of stents; 120 of 334 elective in-patients where delays of between 2-41 weeks were identified in the dictation of clinical notes with potential impact on their cancer diagnosis and prognosis (of which one case is being screened as a potential Serious Adverse Incident (SAI)); and, a further 36 patients with no record of care noted on the regional NIECR system. A further two recent cases are also being screened as potential SAIs.

5. The Trust has further advised officials that the cohort comprises approximately 230 patients who may have received sub-optimal care, and that the full scope of the Consultant's practice (i.e. work potentially carried out in other Trusts, in cross-border or in private healthcare settings) is not currently known.

6. An internal Trust meeting is planned for Monday 10 August to progress the matter and consider potential SAIs. In the meantime the following actions have been commenced.

Current action

7. Prior to retirement the Trust had restricted the Consultant's clinical practice and access to patient information. It has also written to the Consultant's solicitor to seek assurance that the Consultant refrains from private practice pending further investigation.

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

8. The Trust has notified the General Medical Counsel and held preliminary discussions with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

9. The Trust will update the Department and HSCB in due course regarding three cases currently being screened as potential SAIs.

10. The HSCB is considering the EA and will provide further comment/advice to the Department if further escalation is deemed appropriate.

Recommendation

11. It is recommended that you note the details in this submission and the following:
    - **Annex A** – Early Alert notification from Southern HSC Trust; and,
    - **Annex B** – lines to take.

Ryan Wilson

Ext no. Personal Information redacted by

Copied to:
Richard Pengelly
CMO Office
CNO
Jackie Johnston
Press Office
Kim Burns
Karen Jeffrey
Joan Hardy
SpAd

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

Annex A

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

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name: Dr Maria O'Kane
Organisation: Southern Health and Social Care Trust
Position: Medical Director
Telephone: [redacted]

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

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

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

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

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- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

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

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- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) [redacted]

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

Forward pro-forma to the Department at: [redacted] and the HSC Board at: [redacted]

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

DOH-00690

FOR COMPLETION BY DoH:

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

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

Detail of follow-up action (if applicable) ……..……

Annex B

Lines to take

- I am aware that the Southern Trust has restricted the clinical practice of a Consultant Urologist.

- The Department takes this matter very seriously and I can assure patients that both the Health and Social Care Board and the Southern Trust are addressing this matter.

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

ANNEX A

UROLOGY ASSURANCE GROUP
DRAFT TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Objectives

In light of the concerns identified a Department-led Urology Assurance Group will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

Membership

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Interim Chief Executive, HSCB/PHA
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Dr Tony Stevens, Interim Chief Executive, RQIA
- Emer Hopkins, Interim Director of Improvement, RQIA
- Shane Devlin, Chief Executive, Southern Trust
- Maria O'Kane, Medical Director, Southern Trust

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

UROLOGY ASSURANCE GROUP
TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Received from DOH on 06/12/2021. Annotated by the Urology Services Inquiry

ANNEX A

Initial call made to Ryan Wilson **(DoH) on** 15th October 2020 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Maria O'Kane	Organisation	Southern Health and Social Care Trust
Position	Medical Director	Telephone	Personal Information redacted by the USI

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

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

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

Further to Early Alert dated 31st July 2020 (attached for ease of reference) relating to the provision of Trust Urology Services additional significant concerns have been brought to the attention of the Trust regarding prescribing practices regarding the medication Bicalutamide by the individual consultant who is no longer employed by Health and Social Care Services.

These additional concerns have been identified following an initial meeting of the Serious Adverse Incident review team which occurred this week. Concerns have been raised regarding the subject's prescribing practices which include use of unlicensed and sub-therapeutic dosages of Bicalutamide which we consider a significant and potentially wide patient safety risk requiring immediate action. Trust staff are working with the HSCB medications team to gain a better understanding of the implications of this latest development in terms of scale and scope and to identify patient groups that may be at risk. It is recognised that this prescribing issue involves medicines that are prescribed by primary care providers on advice from the secondary care team.

In addition to this early alert senior staff at HSCB, PHA and Department of Health have been briefed directly of this development. The Trust is continuing to liaise directly with colleagues in each organisation in order to take appropriate action.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr Maria O'Kane

Contact details:

Email address (work or home) Personal Information redacted by the USI

Mobile (work or home) Personal Information redacted by the USI Telephone (work or home)

Forward pro-forma to the Department at: Personal Information redacted by the USI and the HSC Board at: Personal Information redacted by the USI

FOR COMPLETION BY DoH:

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

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

Detail of follow-up action (if applicable) ……..……

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

FROM: **MICHAEL O'NEILL**
GENERAL HEALTHCARE POLICY DIRECTORATE

DATE: **20 NOVEMBER 2020**

TO: **1. RICHARD PENGELLY (Cleared 23/11/20)**
2. MINISTER SWANN

INV-1873-2020 (SUB-2174-2020): ORAL STATEMENT TO THE ASSEMBLY REGARDING THE ESTABLISHMENT OF A UROLOGY PUBLIC INQUIRY

SUMMARY:

ISSUE:	You have agreed to provide an oral statement to the Assembly on the establishment of a Public Inquiry into the practices of Urology Consultant formerly employed by the Southern HSC Trust.
TIMING:	**IMMEDIATE.** The oral statement has been arranged for Tuesday 24 November 2020 with the time to be confirmed.
PRESENTATIONAL ISSUES	Media interest in this issue remains high. Press Office is working closely with SHCST, HSCB and PHA on an agreed communications approach and media handling. Press Office will continue to monitor the situation closely. (Cleared (PC))
FOI IMPLICATIONS	Consideration should be given to Section 30 – investigations and proceedings conducted by public authorities.
EXECUTIVE REFERRAL:	N/A
FINANCIAL IMPLICATIONS:	There will be a financial implication in establishing a public inquiry, although the extent is not fully known and will be developed over the coming weeks. However, any additional costs of taking forward a Public Inquiry or other type of inquiry/review would add to the existing in-year issues. With a challenging budget environment going forward any additional funding requirements such as these will continue to increase the pressure on the future financial position. The Department would therefore need to secure the additional budget cover in future budget settlements to cover these inescapable pressures. (Cleared by Finance DK 23/11/20)

Received from DOH on 09/12/2021. Annotated by the Urology Services Inquiry

LEGISLATION IMPLICATIONS:	None required.
RECOMMENDATION:	That you note this briefing and approve the establishment of a statutory Public Inquiry relating to the Urology concerns at the Southern Trust**.**

Introduction

1. You have agreed to provide an oral statement to the Assembly updating MLAs on concerns surrounding the practice of a retired consultant urologist and to announce a Public Inquiry to investigate the concerns. The statement will take place on Tuesday 24 November 2020, a draft will follow as soon as possible.

Background

2. Detailed background to this case was provided in SUB-2055-2020 relating to your written statement to the Assembly on 27 October 2020. In that previous statement (attached at **Annex A** for information) you committed to making an oral statement as soon as possible to provide further details regarding the lookback exercise that is ongoing.

3. Since your last written briefing, the Urology Assurance Group has been meeting weekly and the Southern Trust have:
    - progressed the initial lookback exercise;
    - fielded approximately 160 calls to their information line;
    - engaged with the General Medical Council on matters arising;
    - taking legal advice on how to best approach the consultant's private patients; and
    - developed patient related support services including counselling, psychological support and family liaison.

4. Given the alignment of many of the concerns raised to date, you will be aware that Brett Lockhart QC, Chair of the Independent Neurology Inquiry (INI), was initially approached to establish whether the INI could be recast to include the concerns

Received from DOH on 09/12/2021. Annotated by the Urology Services Inquiry

arising with this consultant. He has politely declined to do so on the basis that there would be an impact on the delivery of his intended INI report.

5. Given the seriousness and extent of the concerns identified to date with this consultant, the establishment of a Public Inquiry, under the Inquiries Act 2005, would be an appropriate legal approach to ensure that the full extent of the concerns are identified and for the patients and families affected to see that these, and all relevant issues, are pursued in a transparent and independent way. It would also be consistent with your decision to convert the Independent Neurology Inquiry to a statutory public inquiry (SUB-2146-2020 refers), following Mr Lockhart's response on the matter advising he is content. Your statement also, therefore, announces your intention to convert the INI to a statutory public inquiry, with communication with patients and families taking place in advance.

6. A Q&A will follow for information.

Financial Implications

7. The extent of the financial implications relating to the establishment of this public inquiry are not yet know. It remains very difficult to offer robust and specific advice on estimated costs associated with this approach, which would depend to a large extent on the individual appointed to lead the inquiry, but precedent would suggest that in general taking a statutory approach is likely to be a more expensive option than a non-statutory inquiry. By way of comparison the Hyponatraemia Inquiry cost approximately £14m, the Historical Institutional Abuse Inquiry was £17-19m for and the RHI Inquiry cost approximately £10m.

Recommendation

8. That you note this briefing and approve the establishment of a statutory Public Inquiry relating to the Urology concerns at the Southern Trust**.**

Annex A – Previous Written Statement

MICHAEL O'NEILL

Received from DOH on 09/12/2021. Annotated by the Urology Services Inquiry

GENERAL HEALTHCARE POLICY DIRECTORATE

Ex: Personal Information redacted by

Copied to:

Richard Pengelly
Jackie Johnston
Dr Michael McBride
Naresh Chada
Lourda Geoghegan
La'verne Montgomery
Ryan Wilson
David Gordon
Kim Burns
Donna Ruddy
Anne-Marie Bovill
Press Office

Received from DOH on 09/12/2021. Annotated by the Urology Services Inquiry

Ministerial Statement

Urology: Southern Health and Social Care Trust

Mr Speaker: I have received notice from the Minister of Health that he wishes to make a statement. Before I call the Minister, I remind Members that, in light of social distancing being observed by the parties, the Speaker's ruling that Members must be in the Chamber to hear a statement if they wish to ask a question has been relaxed. Members still have to make sure that their name is on the speaking list if they wish to be called, but they can do this by rising in their places as well as notifying the Business Office or the Speaker's Table directly. I remind Members to be concise in asking their questions. This is not a debate per se, and long introductions should not be entered into.

Mr Swann (The Minister of Health): Mr Speaker, it is with deep regret that I inform the House of a further occurrence of serious concerns about the clinical practice of a hospital consultant notified to my Department by one of our health and social care trusts. The incident concerns the clinical practice of a urology consultant, Mr Aidan O'Brien, who retired from the Southern Trust earlier this year.

On 31 July 2020, the Southern Trust contacted my Department to report an early alert concerning the clinical practice of the consultant. The trust informed my Department that, on 7 June, it became aware of potential concerns regarding delays in the treatment of surgery patients who were under the care of the consultant urologist employed by the trust. The trust became aware that two out of 10 patients listed for surgery under the care of the consultant were not on the hospital's patient administration system at that time. As a result of those potential patient safety concerns, an initial look-back exercise in relation to the consultant's work was conducted to ascertain whether there were other areas of potential concern.

The initial look back, which considered cases over an 18-month period of the consultant's work in the Southern Trust from 1 January 2019 to 30 June 2020, concentrated on whether patients had had a stent inserted during a particular procedure and if the stent had been removed within the clinically recommended time frame. The initial look back identified concerns with 46 cases out of a total of 147 patients who had the procedure and were listed as being under the care of the consultant during the period addressed by the initial look-back exercise.

When my Department was contacted on 31 July, the trust confirmed that the following actions had already been taken: discussions with the GMC's employer liaison service had been conducted; the case had been discussed with NHS Resolution, which recommended restrictions of clinical practice; restrictions were put in place by the trust preventing the consultant from undertaking clinical work in the trust and denying him the access or ability to process patient information; the trust requested that the consultant voluntarily undertake to refrain from seeing any private patients at their home or any other setting and that he confirm the same in writing; and a preliminary discussion was undertaken with the Royal College of Surgeons' invited review service regarding the consultant's practice and the potential scope and scale of any further look-back exercise that may be required.

The trust also established a review group to assess the further findings of the initial look-back exercise and to explore the potential need for a further look-back exercise in the context of the

emerging concerns. That group has been working diligently since August, and I am now in a position to inform the Assembly of its most recent findings. Whilst Mr O'Brien has worked in the Southern Trust for 28 years, in consultation with the Royal College of Surgeons, the review group has looked at the time frame from 1 January 2019 until 30 June 2020. During that time, 2,327 patients were under his care. The review group identified the most vulnerable group of urology patients in that cohort and concentrated on those patients initially.

There are areas of concern relating to elective and emergency activity; radiology, pathology and cytology results; patients whose cases were considered in multidisciplinary team meetings; oncology; and the safe prescribing of an anti-androgen drug outside established NICE guidance in the management of prostate cancer. Across those areas, to date, 1,159 patients' records have been reviewed, and 271 patients or families have been contacted by the trust. The group's work continues across those areas of concern. Further details of the various review strands are appended to the statement.

So far, nine cases have been identified that meet the threshold for a serious adverse incident (SAI) review, and all nine patients and/or their families have been contacted by the trust to inform them of the position of their respective cases. A further six cases are being reviewed in more detail to establish whether those patients have come to harm.

The consultant also had a significant amount of private practice. Much of that was carried out in private domestic premises and, therefore, sat outside the regulatory framework that requires the registration and external assurance of facilities in the independent sector in which clinicians may undertake private practice. That is also of significant concern to me, as many of those patients may be unknown to the Southern Trust or the wider Health and Social Care (HSC) system.

Following a recent media report about the developing situation, the trust has issued a statement and has advised patients that, if they are concerned about aspects of their urology care and require further advice, they should contact the Southern Trust by email or through its urology information phone line. That information line is available from Monday to Friday between 10.00 am and 3.00 pm, and the number is 0800 4148520.

I am sure that the House will agree that the issues identified by the trust's review group are of the gravest concern. The impact of the concerns will be felt most severely by the patients and families affected, and, unfortunately, we are only at the start of what is likely to become a long and detailed investigation of the matter. As Health Minister, I want first to unreservedly apologise to the patients and their families for any upset and distress that has been caused. I wish to reassure them that I will endeavour to ensure that they obtain appropriate treatment and support and the care that they need over the coming weeks and months.

I propose to take a number of actions to uncover how the situation developed over a number of years without any apparent action being taken by the trust to deal with the practice of the consultant before now. I need to determine quickly whether a further look-back exercise is required that might necessitate a significant review and recall of a larger group of patients, other than those identified to date, who require a review of their clinical care and treatment. In addition to that, given the large number of cases that have been identified as meeting the threshold for an SAI review, particular action will be required to ensure that matters relating to those patients and their care and treatment are dealt with in an effective and timely way.

Received from Ryan Wilson on 02/09/22. Annotated by Urology Services Inquiry

I have therefore taken the following actions. First, I have established a urology assurance group, chaired by the permanent secretary of my Department, to provide external oversight of the various work streams arising from the initial look-back exercise initiated by the Southern Trust. Specifically, that group will review the progress of the initial look-back exercise; consider emerging strategic issues; commission and direct further work as necessary; monitor the impact on urology and related services in the Southern Trust; ensure coordination with other associated reviews or investigations; and oversee communication across all stakeholder groups, with patient care being the central focus throughout. I have published the terms of reference for the group alongside the statement. Secondly, the Royal College of Surgeons has been commissioned to carry out an independent review of a sample of the clinical cases included in the initial look-back exercise to determine whether a further, more extensive look-back or patient recall by the trust is required. Thirdly, in relation to the consultant's private patients who are not known to the Southern Trust, I have requested that Mr O'Brien's solicitors outline how he intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. While the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all that I can to safeguard patients who may have received care or treatment in a private capacity from the consultant.

The remaining issues to be addressed relate to the management of all past, present and future cases that would meet the threshold for an SAI review, as well as establishing why this happened and whether action could have been taken by the Southern Trust to identify and address the apparent deficiencies in the consultant’s clinical practice. Given the large number of cases already identified as meeting the threshold for an SAI review and my concerns that there may be more to come, a different and specific approach is required. The fourth action, therefore, that I intend to take is to establish a statutory public inquiry under the Inquiries Act 2005. I believe that that is the best way to ensure that the full extent of the concerns is identified and for the patients and families affected to see that those and all relevant issues are pursued in a transparent and independent way. My officials are preparing the way to get the inquiry up and running as soon as possible. That will take some time, and I would expect that the respective families and patients will have the opportunity to influence the inquiry's terms of reference. I must also be mindful of the statutory duties placed on me to discuss the issues with the appointed chair in advance of establishing the inquiry. Further details will be provided in that regard when they are available.

Inevitably, this type of work leads to a range of statistics relating to patient numbers, records reviewed, patient contacts and so on. Members will know that, behind every statistic, there is a patient, a family and their story and experience. These types of exercise can cause upset, distress and anxiety.

A significant element in all this work, therefore, will be to communicate with and support patients and their families as much as possible in the coming weeks and months. To help with that, the Southern Trust is developing a patient support package to include any counselling and psychological support that is needed, alongside the provision of family liaison and related support services.

10.45 am

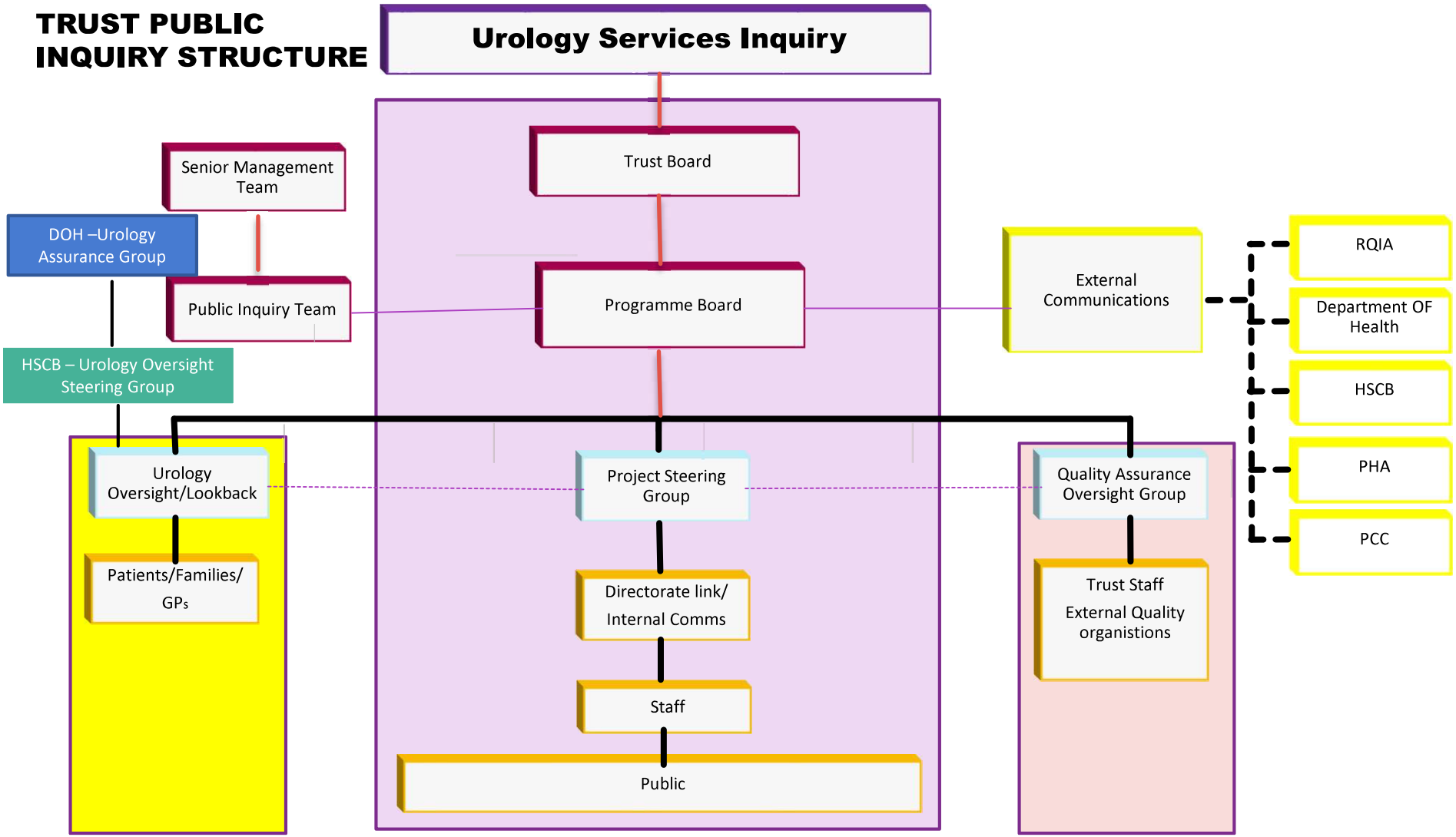
Members will be all too aware that these significant concerns come hard on the heels of the recall of neurology patients by the Belfast Trust, and I am sure that Members will be keen to see the outcomes

of that inquiry in due course. I recently met patients and families affected by the neurology recall and reiterated my apology to them for how they had been let down by the Health and Social Care system. To address those cases, as Members will know, an independent inquiry was initiated by the Department. That inquiry was established in the absence of Ministers, when it was not possible to constitute the inquiry under the Inquiries Act. To date, the work of that independent inquiry has been largely unaffected by that non-statutory approach, and I take the opportunity to thank Brett Lockhart QC and his team for their immense efforts in recent months. However, to ensure that, in the closing stages of the neurology inquiry, Mr Lockhart and his team have timely and unfettered access to all relevant information, I also announce that I intend to convert the Independent Neurology Inquiry to a statutory public inquiry under the Inquiries Act 2005. It is important to note that the inquiry team is at a very advanced stage of its evidence-gathering process, and I want to be clear that I do not intend this decision to add to or alter the work or timescales of the neurology inquiry team, nor do I expect to see changes in the way that evidence has been gathered or public access has been provided. That would not be in the interests of the patients and families affected. They have already waited too long for answers. My officials will be in contact with Mr Lockhart as soon as possible to ensure that the transition is as seamless as it can be.

The emerging situation in the Southern Trust causes me and my Department the gravest of concerns. While I remain convinced that the experience of patients who use our health service is overwhelmingly that of a safe and quality service, these incidents, regrettably, dent the confidence of service users. I fully acknowledge that, and I will do all that I can to ensure that lessons are learned to prevent situations such as these occurring again. I trust that Members will agree that what I have announced today constitutes robust and timely action in a deeply concerning situation. I commend my statement to the Assembly.

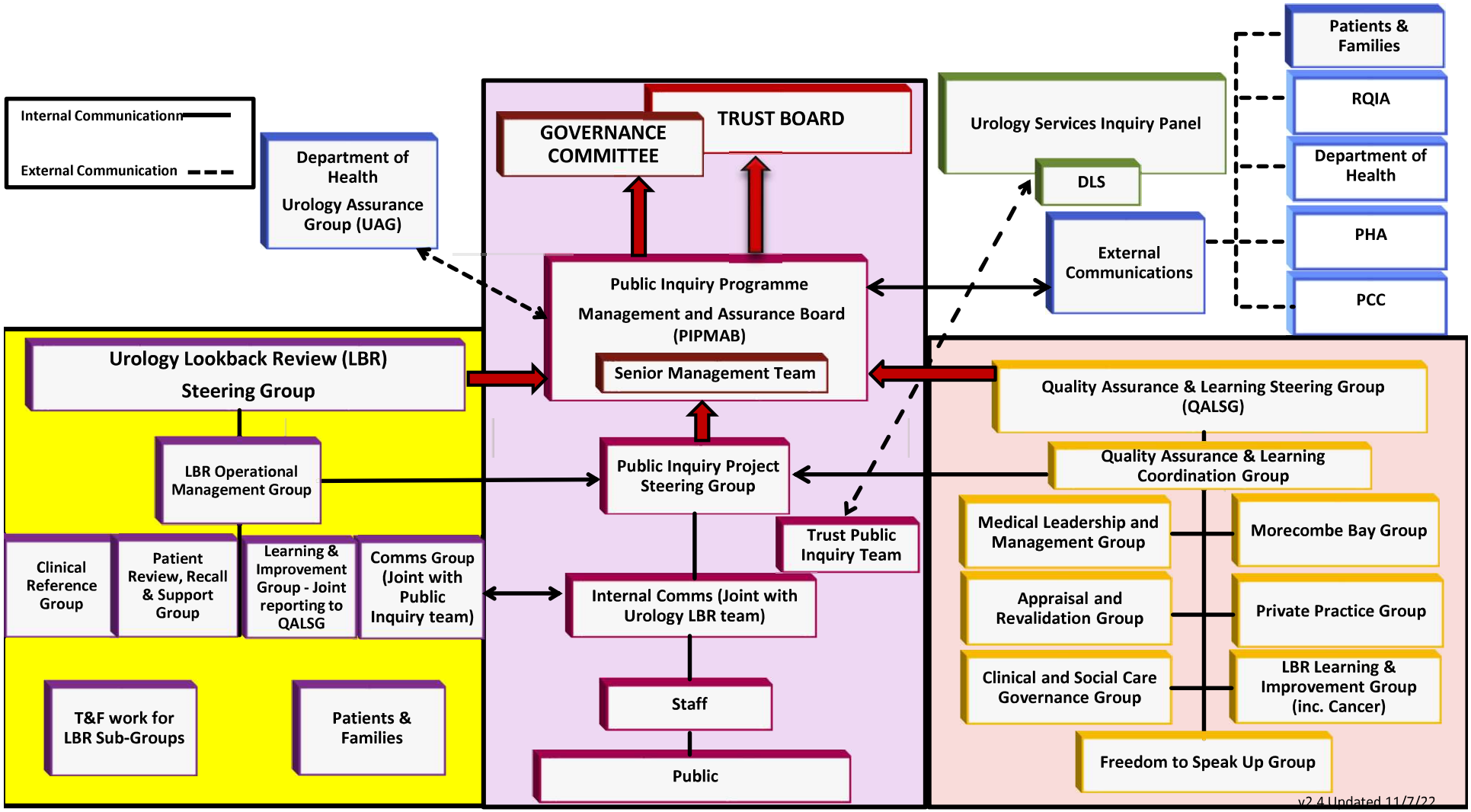
Received from SHSCT on 01/02/2023. Annotated by the Urology Services Inquiry.

TRUST PUBLIC INQUIRY STRUCTURE



Received from SHSCT on 01/02/2023. Annotated by the Urology Services Inquiry.

Public Inquiry Programme Structure
(Incorporating the Urology Lookback Review & Quality Assurance)



2.16. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

2.17. Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Business Services Organisation

2.18. The BSO, which is established as the Regional Business Services Organisation under Section 14 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, contributes to health and social care in Northern Ireland by taking responsibility for the provision of a range of business support and specialist professional services to other health and social care bodies, as directed by the Department in accordance with Section 15 of the Reform Act.

2.19. The BSO incorporates the majority of services previously provided by Central Services Agency. The BSO, however, provides a broader range of support functions for the health and social care service, bringing together services which are common to bodies or persons engaged in providing health or social care. These include: administrative support, advice and assistance; financial services; human resource, personnel and corporate services; training; estates; information technology and

Received from DOH on 08/12/2021. Annotated by the Urology Services Inquiry

THE INQUIRY RESUMED ON TUESDAY, 9TH APRIL 2024, AS FOLLOWS:

CHAIR: Good morning everyone. Apologies for the delay. I think we're back to "Technical Tuesdays". And in fact we seem to have difficulties on a great number of Tuesdays, but hopefully we can get on with things now. So, Mr. May.

MS. McMAHON: Good morning, Chair, members of the Panel. The witness this morning is Mr. Peter May, who is the Permanent Secretary of the Department of Health, and he wishes to affirm.

MR. PETER MAY, HAVING AFFIRMED, WAS QUESTIONED BY MS. McMAHON KC AS FOLLOWS:

MS. McMAHON: Good morning, Mr. May. My name is Laura McMahon. I'm junior counsel for the Inquiry. We met before, so welcome back.

A. Yes, good morning.

1 Q. You were our first witness a while ago, and you're almost our last, but today you've been called back so that the Panel can get an update on where we are since we started, and perhaps some further clarity on some evidence that's been provided by other witnesses as well. So, you have previously provided written evidence in the form of a previous Section 21 notice, and for the Panel's note that was dated 18th August 2022 and can be found at WIT-42367. You also gave

evidence previously on 15th November 2022, and for a note, the transcript of that can be found at TRA-00707. And after you gave evidence you kindly provided us with further information and clarity on issues that had arisen on that occasion, and the response to questions that we've asked can be found at DOH-71042. And those replies are dated 15th November 2022. 10:15

In order to allow an update, we sent you a Section 21 No. 1 of 2024 earlier this year, and you replied to that on 22nd March 2024. And if we can just go to that Section 21 notice at WIT-107060. And you'll see that that's No. 1 of 2024. Your name is at the top of that statement. And your signature can be found at WIT-107122. Do you recognise that as your signature? 10:15 10:16

A. I do.

2 Q. And it's dated 22nd March 2024. Do you wish to adopt that as your evidence?

A. Yes.

3 Q. Now, we will be relying substantially on that statement. I'm going to pick out some of the issues that you've brought to our attention, and you've provided an addendum to that notice more recently, and that can be found at WIT-107624. Again, your name at the top of that and your signature can be found at WIT-107640. And, again, do you recognise that as your signature? 10:16 10:16

A. I do.

4 Q. And the date is 29th March 2024, and do you wish to

adopt that as your evidence?

A. Yes.

Q. Thank you. Now, the addendum statement provides us with further information, and I'll go between the statements as necessary just to draw the Panel's attention to where we're at at the moment. But for the purposes of today, the structure of your evidence, I will take you through some of the headings that we'll cover within the time allocated. Firstly, we'll look at the SPPG structure and the new commissioning arrangements. Secondly, we'll look at Information Systems in Health and Social Care. Thirdly, Standards For Quality and Patient Safety. Fourthly, we'll look at reform and reviews. Then we'll look at culture and driving change. No.7, we'll look at workforce issues. 8, we'll touch on innovations around hearing the voice of the patient. And lastly we'll look at learning from other inquiries and what's anticipated the learning from this Inquiry and how that might be managed going forward.

10:17
10:17
10:18
10:18

So, what I plan to do is just take you to various sections of your Section 21 and ask for some clarity or explanation as appropriate.

10:18

Now, the starting point of your further Section 21 is that since your evidence on the last occasion the Inquiry had the opportunity to hear from your predecessor Richard Pengelly, and you reviewed

Mr. Pengelly's statement and evidence, and although you have, don't have knowledge of all the aspects that he refers to, naturally as you took over from him, you were in overall agreement with the evidence provided by him? 10:19

A. That's correct.

6 Q. Now, just moving on to the first heading "SPP Structure and the New Commissioning Arrangements". Now, we have heard from Paul Cavanagh and Sharon Gallagher, who provided evidence on behalf of SPPG, and they explained 10:19 the new structure, just some of the nuances around that, just so we're clear in our understanding of that. They are no longer an arms length body. The HSCB prior to that had been, but the positioning of SPPG changes that somewhat. And as we understand it, the SPPG sits 10:19 within the Department and under your general authority, is that a fair explanation of that position?

A. Yes, it is. I wonder just before I say more if I could just make two very brief introductory comments? The first of which is to reiterate the apology I made on 10:20 behalf of the Department to all of those who have been affected, including particularly, obviously, patients and families in relation to the work of the Inquiry. And, secondly, just to recognise the huge amount of work that this Inquiry has already done over 90 days of 10:20 hearings. And I realise, as you said, you're nearing the end of that particular phase of the work of the Inquiry, and just to signal my intention today is to try to assist the Inquiry as best I can. If at any

point there's a question I don't know the answer to, particularly if it's factual in nature, I would like to offer that I would write to the Inquiry and provide that information thereafter, if that's acceptable to the Inquiry? 10:20

7 Q. That's very helpful. Thank you. And if we do come across any queries that either I can't explain further on the evidence or you need more information about, we can follow that up in correspondence after today's evidence. 10:21

A. So just turning then to the SPPG and it's place in things. You're correct to say that SPPG is now part of the Department of Health. The Health and Social Care Board was it's predecessor and it ended in 2022. Indeed the life of the Board ended the day before I took up my role. So I wasn't party to the legislation and the detail of the legislation, but I understand that a succession of health ministers had taken the view that the commissioning space was overly cluttered and that they wished to try to create a simpler and more straightforward approach, and that the removal of the role of the Board was one element of that, as is a more general change to the way in which commissioning takes place. 10:21 10:21

8 Q. And one of the outworkings of this renegotiation of the structures, it sounds like it was based on a desire for efficiency around commissioning, but one of the outworkings of that was that we've heard that the duty of quality doesn't apply to SPPG and had applied to the 10:21

previous Health and Social Care Boards. You've provided further detail on that in your addendum statement in, and in summary form it would appear to be that because of the functions now carried out by SPPG and the way in which services are reconfigured under this new structure, that the legislative requirement, or the attachment to a duty of quality under the legislation to the HSCB falls away under SPPG, purely by drafting mechanisms it seems, but can we assume the expectation is that the duty of quality in general terms, although not a legislative requirement, is something that is imported into the mindset and the service provision of SPPG? 10:22 10:22

A. Well, absolutely, it's still a critical part of the work that SPPG does to oversee the quality and safety agenda working in partnership with the Public Health Agency. The reason for the change is that in 2003 when the duty of quality was first introduced, it was specific in relation to -- for care for individuals. At that time the predecessors to the Health and Social Care Board did have some responsibilities for care to individuals, particularly in the childrens and social care space. Those responsibilities were transferred in 2009 when the Health and Social Care Board was established, but in practice the Board itself didn't perform those functions, it delegated them to Trusts. Clearly if it's legally responsible it still had an accountability for the delivery of those functions, but in 2022 the decision was made that those functions 10:23 10:23 10:23

should sit with Trusts, they had been carrying them out for many years, and it made more sense for Trusts to have that role. Hence the SPPG no longer had a role in relation to individuals. So, as you say, it's a consequence of the way in which the legislation was drafted that the duty of quality then didn't apply to SPPG in that formal sense. But there are many ways, and we'll come on to them no doubt in the rest of the evidence, in which SPPG does play a critical role in relation to the quality agenda. 10:24

9 Q. If we look at your statement at WIT-107063, you've made reference to broad oversight arrangements in relation to SPPG at paragraph 9. And when you say "the group", in this context you're referring to SPPG, and you say the following: 10:24

"The group is subject to the same scrutiny as the rest of the department by the Departmental Board which includes two Non-Executive members. The Department's Audit and Risk Assurance Committee was established to 10:24
advise the accounting officer, through the Departmental Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. The Committee membership comprises of two 10:25
Non-Executives of the Departmental Board and a further two independent external members. The oversight of the committee extends to SPPG and those former functions of the Board which are now under the direction of the

Department."
There had been some evidence received from some of the other arms length bodies around the oversight provided to them by their own individual boards and how they considered that to be significant in terms of governance. Are you content that the new arrangements allow for the continuity of good governance in relation to the functions, the now functions of the SPPG?
A. Yes. I think the other thing that isn't drawn out in paragraph 9, and perhaps could usefully have been, is, the Department is accountable to the Northern Ireland Assembly, and the Health Committee very directly, and the work of that Committee will oversee the work of all of the Department, including SPPG. Obviously the Committee also looks at the work of arms length bodies, but it tends to have a particular focus on the Department.
10 Q. If we go to the next page at paragraph 15 and 16. When the Chief Executive of the RQIA gave evidence she informed the Panel that the SPPG, or the RQIA, has no oversight role in relation to SPPG, where they had had previously with HSCB, and you deal with that at paragraph 15 and you say the following:

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

And at 16:

"The new relationship with SPPG is being redefined and will reflect SPPG's constitution as part of the Department and its core functions as set out above." 10:27

So that explains the reason why. Again, it falls back to the reconfiguration. When you say the new relationship with SPPG is being redefined, what is it that you're referring to in that particular paragraph? 10:27

A. Well, I think that the logic is that it may well be that there needs to be some form of a service level agreement or something that's put in place, or a Memorandum of Understanding, as to how the RQIA can take account of the functions of SPPG where they're relevant. 10:28

I think for me it wouldn't be sensible to suggest that RQIA would be the right organisation, for example, to do a review of commissioning or planning within Health and Social Care. But if they were doing a scrutiny, or an inspection, a review, within a Trust or across our Trusts in relation to a particular speciality and an issue arose in relation to commissioning, then it would seem perverse to me that they weren't able to follow that thread back into the work that SPPG does. So, it's to try and set that kind of nuance in place so that there's not a barrier there to the RQIA being able 10:28 10:28

to conduct it's work in the way that it needs to.

I think that there's probably a wider dimension to this that's worth drawing out and which I suspect you may come to later, which is, the Department has a desire do 10:29
a review of regulation more generally. There was some work done prior to the pandemic in relation to that. I think that work needs to be updated, and I think it was never entirely comprehensive in any case.

10:29

We are currently, and again this maybe a theme of the evidence I give, in a resource constrained environment, and as a result we've not been able to move ahead with the review of regulation. I think there are some other better reasons why we've also not yet moved on the 10:29
review of regulation, which again I think you will come to later in the evidence that you're asking me to give.

So I do think that there's scope to look again at some of these in that review of regulation and to understand 10:29
whether there are any lacunas as a result of the changes made which the draughtsman and the people who led the policy for the legislation I think were accurate in redefining the roles, but we just need to make sure that we've got a system that works always 10:30
now.

11 Q. And just you've mentioned the RQIA and the work done prior to the pandemic. I'll perhaps just take the Inquiry to the paragraph in your addendum statement

that deals with that at WIT-107632. Paragraph 32. And just what you've said, you say at paragraph 32:

"Prior to the COVID-19 pandemic the Department had developed a new draft regulatory policy framework. However, further development work is required, including consultation on the draft policy. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context, work on the review of the regulation is currently paused to allow for other priority projects to progress." 10:30 10:31

Now, we'll look shortly at the reforms and reviews that are ongoing, but from the regulatory point of view that's on hold? 10:31

A. It is at the moment, yes, and the decision was made that there were other things that we needed to advance more urgently and with a view to creating the right environment within which to do the review of regulation. In my experience, if you look at regulation, if you approach regulation at a time when you don't have the system in the place that it needs to be in, you can end up with an overly defensive reaction and it can be very hard to bring about change. Whereas, one of the things that we've been looking to do is to advance those areas that will develop and bring about cultural change within the organisation, 10:31 10:31

such as the review of SAIs, through the review of MHPS, the Raising a Concern Policy that was published in March, and so on. So I don't want to go over all of those because I know you'll come to those, but it's just to signal that by making those changes we're trying to create a different environment within which then to locate the review of regulation, and we think that that is a better way to go about the ordering of the work.

12 Q. And we go back to your original statement then at WIT-107083. Just deal with the regulation point now. 10:32

A. Sure.

13 Q. As we've moved onto it. Paragraph 77. And just for context, the question that we asked you and the answers I'm going to read out relate to the following question: 10:32

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

10:33

And you say the following:

"As I have acknowledged in my response to Question 7, the regulatory landscape is already a complex one with a range of bodies discharging various roles and functions which exerts some measure of regulatory influence either direct or indirect. Further, research and studies in the UK and beyond have acknowledged the vast range of regulatory interventions in health care 10:33

systems more generally, the number of bodies involved and vast resource expended."

Paragraph 76:

10:33

"Further regulation should not be a default option and seeking to introduce more regulation in response to a significant service or system challenge, in particular given current pressures on the system, may not always be the best response." 10:33

Paragraph 77:

"The Department has acknowledged, however, that the current legislation underpinning the regulation and 10:34 inspection of health and social care services and the roles and functions of the RQIA dates back to 2003. The delivery and provision of health and social care has evolved significantly in the intervening period. A future review of regulation would provide a platform to 10:34 consider any identified improvements in the regulation and monitoring of services, and to consider what is the right model of regulation across the full system and sectors of health and social care provision.

10:34

78. A new draft regulatory policy framework had been drafted prior to the COVID-19 pandemic. However, further development work is required, including consultation on the draft policy."

And then you make your point about the budgets. And then at paragraph 79:

"There is also a need to balance regulatory intervention with support for learning, improvement and development. The Department is progressing a number of policy strands designed to further support and help embed an open, just and learning culture across our HSC, aimed at better supporting staff and patients and ultimately delivering improved care. This work recognises and takes account of emerging evidence and practice." 10:34 10:35

And then just to finish that at paragraph 80: 10:35

"A core ambition of this work is to further enable an environment which identifies and learns system wide lessons when things do not go as planned in delivery of care, to deliver system improvement and leading to better outcomes for patients and staff providing services. This is best achieved by creating a psychological safe space supporting staff to engage openly in learning processes as part of an open and learning culture, avoiding a blame culture, which is counterproductive. This also supports staff to communicate early with patients and families in a compassionate, open and honest manner. Where an incident or event requires accountability for action, 10:35 10:35

this should be proportionate, just, and prompt, taking account, where relevant, of system factors. An open just and learning culture which co- exists with appropriate and just accountability is key to support delivery of safe and compassionate care and protecting the welfare of our staff."

Just in relation to paragraph 80, that seems to set out in general terms the basis for any regulatory system or governance system, in that people should feel safe to either trigger or bring to other's attention concerns that they have, and that those concerns should be dealt with swiftly, justly, and speaking with all relevant stakeholders. 10:36

Given that the regulatory pause that's been put on the developments so far because of budget constraints, are you content that that pause will not detrimentally impact the current governance arrangements that are in place through the Trusts? 10:37

A. Yes, as I tried to draw out in the answer to my previous question, I think the budget is one thing, but there's also if you try to change everything at once then in my experience that doesn't work well. So I've tried to set out why there's a logic in trying to address the kinds of projects that we are taking forward in relation to SAIs, the Being Open Framework, which I didn't reference earlier, the work on MHPS those are all things that I think are enabling measures 10:37

that should support the review of regulation and make that work better in due course. So, yes, budget is a constraint, but it's not the only reason why we've done it the way we've done it, and I think if you try to do all of those things at the same time, that would be more change than the system could reasonably be expected to accommodate at any one point, and then you end up with the risk that people don't understand what it is that you're trying to put in place. 10:37

14 Q. And just to complete the point, you've mentioned some of the work underway, and at paragraph 82 you deal with -- provide some examples of that. Paragraph 82 says: 10:38

"Work underway led by the Department to support this policy agenda includes, but is not limited to, an emerging Being Open Framework, the redesign of the SAI procedure, early work on an underpinning charter, the recently published Raising Concerns HSC Regional Framework..." 10:38

-- and you've provided a copy to us:

"Ongoing review of Maintaining High Professional Standards, work due to commence shortly with the Northern Ireland Public Sector Ombudsman to review the HSC complaints procedure and a review of HSC Occupational Health services." 10:38

Now that's work that's ongoing and is it the case that

the issues that have arisen through this Inquiry, and that have been made public through evidence, is the learning from that on an ongoing basis being used to inform, where appropriate, some of the work that's already planned or in place? 10:39

A. Yes, that's absolutely right, and it's also the case that previous inquiries have made recommendations in a number of these areas as well, particularly the Neurology Inquiry. So we've been seeking to take the learning from all of these incidents and inquiries to 10:39 make sure that we put in place something that is designed to make the system work better in the future. All of the areas that are referenced in that paragraph that you quoted there have involved very heavy levels of engagement with clinicians and people who work 10:39 within the health and social care system. So this isn't something that's being done in some sort of isolated way, it's very much being done engaging with people who work in the system in a number of the areas. There has been relatively recent reviews and changes 10:40 made, for example in England, where we can also look to learn from experience there, and I think that that's been very helpful to us in a number of areas, because these problems are not unique to Northern Ireland. They are -- some of the challenges you face trying to 10:40 create a system that has the right balance is true everywhere and, you know, we need to make sure that we are absolutely focused on getting the right balance rather than if you move too far in one direction then

you often find that that has unforeseen consequences that also bring about negative outcomes in different ways.

15 Q. So there is an active focus on looking at what has already been learned from other jurisdictions? 10:41

A. Absolutely.

16 Q. And importing that as is possible.

A. Yes. And a number of the reviews will either have individuals who have direct experience or will have made a point of going to talk to those individuals 10:41 themselves.

17 Q. I just want to ask you a couple of questions about the new commissioning model. You've mentioned it in explanation of the restructuring around SPPG and the HSCB. There had been some suggestion in the evidence 10:41 given by Chief Executive of the PHA, and just for the Panel's note Mr. Dawson's evidence is at TRA-10732 to 10736, and in general terms, Mr. May, he set out some of the changes the new legislation has brought in, and one which is that the previously legislative 10:41 requirement of a dual mandate for commissioning between the PHA and the HSCB, SPPG, no longer requires the PHA signoff under the new legislative framework, and I just want to ask you -- I think that was before your time that the legislation was drafted and the legislative 10:42 intent, I don't want to ask you information about background to legislation that you've no knowledge of, but do you get a sense that that was intentional to streamline commissioning services, and do you have any

concerns that the absence of a dual mandate for commissioning services in any way dilutes potential oversight or governance?

A. So my understanding is that the intent was not to somehow cut the Public Health Agency out of the commissioning process. I think I'm clear that the PHA needs to work hand in glove with SPPG in order to deliver, whether you call it commissioning or planning process, whatever, the way in which you go about procuring the services that are needed from the health and social care system. They have unique expertise around population health and a range of other areas, which are absolutely intrinsic to the delivery of that system. 10:42 10:43

My sense, although I have not seen this written down, my sense is that this may well have been a consequence of -- a natural consequence of the way in which the Board was being, it's role was ending and being brought within the role of the Department, because prior to that the legislation, as I understand it, had said that -- it was, as you say, a dual mandate between the Board and PHA, but in the event that there was not agreement then it would be for the Department to decide. Clearly if SPPG is also the Department then that becomes, legislatively it becomes a bit of a nonsense. So I suspect that the decision was taken not to make it a requirement on the first hand when the port of appeal would be to another part of the same entity, but rather 10:43 10:43 10:44

-- so I think that was the intent that lay behind it.

As I said, I think I am clear, I know SPPG is clear that this is -- this has to be a joint enterprise and one that works together. So I don't, I have not identified any difficulty in practice yet with this approach. Of course if there are, and I don't believe that Mr. Dawson drew out any practical challenges in his evidence, so I'm happy to keep that one under review if there's a need to look again. 10:44

I do know in other areas, for example, in safety and quality, there has been a service level agreement put in place between the PHA and SPPG that defines roles and responsibilities, and I know there's ongoing work to look at how that could work more widely as well. 10:44

18 Q. And you've provided an example in your statement of how that new arrangement and the expectation of the parties may be reflected in the HSC Framework Document. I'll take you to that at WIT-107065, paragraph 20. Yes, paragraph 20. You say: 10:45

"Following the minister's decision, the HSC Framework Document will be updated to reflect the new commissioning approach which cements the role of SPPG and PHA in jointly planning and managing health and social care services, following its implementation later this year." 10:45

At 21 you say:

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

And at 22 you say:

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

Mr. Dawson in his evidence highlighted the areas of expertise his staff have and, as you say, they have expertise around population health and also individual expertise among their own, some of which are clinicians and other health care professionals?

A. Indeed.

19 Q. So we can take from what you've said in your statement that it's anticipated that partnership agreements, drawing on expertise in order to better inform commissioning and planned services decisions is something that should be taken as read at this point?

A. Yes.

20 Q. I wonder if I could take you to just an extract from evidence from SPPG from Sharon Gallagher. It's at TRA-11055. And this is around the delivering of safe services. Line 15 is my note, but I might need to take you back to the question just so you know the context. Yes. I was asking a question in relation to what Mr. Devlin had said in his Section 21, and giving he had set out some criticisms, his views of the way the SPPG and the HSCB were operating at that point at the time of the Section 21 to give Mrs. Gallagher and Mr. Cavanagh an opportunity to update and explain what they considered about his view. And Ms. Gallagher then, just the next page down, please, at line 16 -- I'll start at line 8 because it will give you the context. 10:47 10:48 10:48

"In terms of the delivery of high quality services, I mean we've talked about this earlier, that sits within the purview of the Health and Social Care Trust, so the targets are part of the picture, but safe quality services sit within the domain of the Health and Social Care Trust. In Mr. Devlin's defence our demand capacity gap has increased. That was made even worse by Covid. So the provision of high quality services as described by Mr. Devlin had, of course, diminished, because we were in a position with ever increasing waiting lists and, you know, during a period of Covid and recovering from Covid. So I can understand why his perception would be that these things had conflated. 10:48 10:49

But as I mentioned earlier, this is a very complex working environment with many, many factors coming into play."

Now, Ms. Gallagher has said that the delivery, the high quality delivery sits within the purview of the Health and Social Care Trust. Just before we move on from the commissioning topic. Who, in your view, has ownership of commissioning safe services? 10:49

A. Well, the responsibility for commissioning of services would sit with SPPG and PHA working jointly in the way that we've just described. I think -- I don't know if it's helpful or not, but I wonder if I try to draw out -- for me I always think about safety and quality of services in two interlocking ways. So the first of those has the individual patient at the centre, and the role that individual clinicians play around that individual, and then all of the clinical governance arrangements that work within the Trust environment, and I think, you know, in a delegated accountability system such as that that operates in health and social care, that's an entirely appropriate model and one that no department or central body could ever hope to play a role, and obviously professional regulators play a role there to. 10:49 10:50 10:50 10:50

The second interlocking way is to think of all patients at the heart, and that is fundamentally the role of the Department, and everybody, to think about how safety

and quality is delivered for all, and there are inevitably -- and Sharon Gallagher was referring to this in her evidence -- if you have a very long waiting lists then the overall quality of care is being affected. So keeping those two interlocking concepts together, and understanding the respective responsibilities for each is the way I tend to think about safety and quality. I don't know if that's helpful, but that's just to try and explain for me, otherwise words around quality and safety can be asked to bear too much weight because they're being asked in different contexts to apply to slightly different things. 10:51 10:51

21 Q. And you've referred to standards for quality and patient safety in your statement, and perhaps just on the back that of we'll move on to that particular topic and look at the way in which the Department views those issues. 10:51

A. Sure.

22 Q. WIT-107075. 107075. At paragraph 51. Thank you. Just in the context of this, for the Panel, we asked you: 10:51

"What is your view of the importance of setting appropriate standards around, for example, quality and patient safety for health care providers? Who is responsible for doing this? Do you have a view on the effectiveness of any groups, committees or organisations in agreeing these standards?" 10:52

And you say at paragraph 50, just by way of introduction:

"Delivery of health and social care services is increasingly complex. It is in the interests of all stakeholders, including HSC Trusts and other service providers, commissioners, and service users and carers to try to minimise complexity where possible. The use of standards is one mechanism to help achieve this." 10:52 10:53

Then at paragraph 51:

"The Department of Health's Quality Standards For Health and Social Care were published in 2006." 10:53

And for note they can be found at DOH-71901.

"These standards remain extant and set out the quality standards that the Department considers people should expect from HSC services." 10:53

Now, just on reading that, the standards would appear to be 18 years old, and the landscape has changed enormously in health care. I'm sure you would agree with that. Is this document reflective of these quality standards for health care that would be expected now, or is it something that's under review or potentially to be re-visited? 10:53

A. Well I think it's good practice to look again at things, you know, after a certain period of time, and so, you know, in due course we would want to do the same with these standards.

10:54

I have to say though, in contrast to the likes of MHPS and SAIs, where I think it's very clear that there are material problems with the process that is in place, I haven't, in the two years I've been in the Department, had anyone come to me to offer a view that these quality standards are badly out of kilter with what is needed today. So I'm not saying they're perfect, I'm sure there are ways they can be improved, but for me that makes them of a lesser priority than the work we've described now and, indeed, the review of regulation that we've already discussed as well.

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10:54

23 Q. And you've been frank about that at paragraph 54, where you say:

"The Department recognises that there are likely to be opportunities and benefits from evaluation and review of the 2006 standards. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context work to review the 2006 standards is not currently planned for the 2024/2025 business year."

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And as you've said, that's entirely reflective of

prioritisation of where problems may be?

A. Yes.

24 Q. And the need to address those. And, again, just back on the point that you had made earlier about there being learning from other jurisdictions. You say this at paragraph 56: 10:55

"Given the relatively small size of the health care ecosystem in Northern Ireland, we do not have the resources to replicate work undertaken by national standard setting bodies and expert groups. To seek to do so would not be good use of public resource. Instead, Northern Ireland is well placed to avail of such standards and to consider these for application in Northern Ireland to protect and improve safety and quality and to participate in development of such standards. Northern Ireland has local processes and systems for assessing and adopting, or otherwise, such standards when they are developed. Consideration is also given to any unique considerations which would require a bespoke Northern Ireland response, although in reality there are few such factors." 10:55 10:56 10:56

And an example of -- you mentioned service level agreements and the potential for use of those at local level, but just on the issue of quality and patient safety, you mention at paragraph 57, one with the NICE, you say: 10:56

"One good example of this is the Service Level Agreement (SLA) that NI has in place with the National Institute For Health and Care Excellence. NICE's role is to improve outcomes for people using the NHS and other public and social care services in England by producing evidence based guidance, quality standards and performance metrics and a range of information services for Commissioners, practitioners and managers across health and social care. The Department established formal links with NICE on 1st July 2006, whereby guidance published by the institute from that date is reviewed locally for its applicability to Northern Ireland and, where appropriate, endorsed for implementation in health and social care. This link has ensured that Northern Ireland has had access to up-to-date independent professional evidence-based guidance on the value of health care interventions. NICE technology appraisals, clinical guidelines, public health guidelines, and COVID-19 Rapid Guidelines are considered and endorsed for Northern Ireland as appropriate. In Northern Ireland HSC Trusts are responsible for implementing NICE Guidelines and the Department's Strategic Planning and Performance Group works closely with the PHA to monitor and seek assurance on implementation." 10:57 10:57 10:57 10:58

The Inquiry has heard evidence on the way in which NICE Guidelines find their way through the filter from the Department. It's clear from your statement that the

Department's responsibility is to access information on standards and quality, or have that fed through the Department and to disseminate that among the Trusts, and then to focus that on areas of clinical practice that would be best informed by those guidelines. So there is that continuity of quality and standards. Is that a fair summary of the Department's role?

A. Yes. And in addition, depending on the nature of the guidance that is being passed out, so there may be some assurance sought from Trusts or others about the way in which they have sought to comply with that guidance. 10:58

25 Q. So there is a level of oversight or an ongoing relationship around that?

A. Yes. Usually through SPPG and the PHA they will be making those judgments. The Department can do so as well, and the Chief Medical Officer would often be involved in looking at what comes through from NICE, for example. 10:59

26 Q. Is that an example, perhaps, of what we were speaking about a moment ago, about how the commissioning of safe services is almost embedded in the system by the fact that the standards and quality assurances, there's an expectation that Trusts will reflect best industry standards? 10:59

A. Yes. 10:59

27 Q. And, of course, in mentioning quality standards for health and social care, you've also made reference to the statutory regulators for the different professions; the GMC, the NMC, and the way in which they interact

with other aspects of standards that are applicable. I wonder if I could just touch on the Trust's Boards and their relationship with the Department. It would seem from the evidence received from many witnesses that they have an important role in overseeing the standards of quality and patient safety, and I just want to just bring up a couple of things that have been highlighted by some of the witnesses.

11:00

First of all, we'll look at your statement where you mention the succession planning for Boards, WIT-107113. Paragraph 168. We've asked you generally questions in relation to problems around recruiting and retaining and developing Board members, both at Executive and Non-Executive members, so we've asked you a few questions around that, and I want to highlight some of your answers. Just paragraph 168. You say:

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11:01

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

11:01

Then at 169:

11:01

"Within my Department the Public Appointments Unit has a comprehensive programme planning process in place. This includes consultation with ALB Chairs on issues

such as monitoring term end dates, agreeing extensions to terms, and second term reappointments, competition scheduling, and once competitions are completed, agreeing the commencement date for new appointees. Where possible Board appointments are sufficiently staggered to ensure that there is appropriate retention of experienced Board members balanced by the influx of new members bringing fresh challenges."

11:02

One of the things that had been highlighted had been that there had, on occasion, been swathes of lost expertise or corporate knowledge around Boards at one time because of the way in which tenures were awarded all at once. Is that something that from those paragraphs would seem to be in the past and there's a recognition that staggering this is a more appropriate way to maintain both expertise and corporate knowledge?

11:02

A. It's certainly something that we've been trying to do more of. I suspect we still have, you know, a bit more to do, but we have made some progress in that respect. In the past, if I go back I don't know, 10 or 20 years, it would quite often have been the case that a minister may have decided to, to have a kind of automatic reappointment for a second term, as it were. Most ministers, in my experience over recent years, have taken the view that they would like anyone who wishes to serve a further term to go through the same process as anyone applying for the first time. That then can mean that you end up losing more experienced Board

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11:03

members at one go than is desirable, and that's why some staggering is helpful. And also, of course, you can't rule out there may be a group of people coming to the end of their second term and best practice is that they wouldn't serve more than two terms. So, yes, we are working to make this better and I think we are making progress in it. 11:03

28 Q. Now, you mention at paragraph 171 that:

"The primary responsibility for providing the resources required to enable Board members to discharge their duties appropriately lies with the individual Trusts within the overall funding provided by the Department of Health." 11:04

So there is that autonomy for Trusts to -- can they make local decisions around how they structure and operate their Boards, or is there a requirement that Boards are set out in the same way across all Trusts?

A. Boards -- Trusts have a lot of delegated authority in respect to how they work. I mean there are some requirements on all Boards to meet best corporate governance standards. So you would always require, for example, an Audit and Risk Committee or whatever it might be. So, you know, there'll be some basics, but I don't think that they are contested. 11:04

The point around resources may be one that emerges on a number of occasions in today's evidence. I think what

I've been trying to do is to move away from a model where the Department might provide money for very specific purposes, because then you start ringfencing funds, and that then, in my experience, often leads to inefficiencies in the way that resources are spent, and a rigidity in the system. Whereas, if you're providing the Trust -- and most of the Trusts are, you know, receiving the best part of £1 billion, Belfast significantly more than that -- if you're receiving that amount of money with a clarity about what it is that needs to be delivered across various domains, then that seems to me a much better way of going, rather than saying "Here's a few thousand here to train a Board member". I mean that becomes, for me, something that invites the Department to start to micromanage in a way that isn't helpful. 11:05 11:05 11:05

29 Q. I just want to read out to you to see if you have any comment on some of the evidence from Board members when they came to give evidence to the Inquiry. Eileen Mullan's evidence can be found at TRA-10022. It's probably unfair to Ms. Mullan to start off with her sentence "These are not attractive roles". She was talking about Board membership and NEDs, and to be fair to her, she spoke very highly of how rewarding these roles are and how committed the individuals, and indeed she is, in fulfilling these roles. So just that's the caveat of what I'm about to read. And she says: 11:06 11:06

"These are not attractive roles. You've got to want to

do this. You don't step into a Health and Social Care Trust as a Non-Exec because you've some time on your hands. You do it because you want to bring your skills, your experience, and your absolute commitment to health and social care to the table. I firmly 11:07
believe, and it is with my Boardroom Apprentice and other hats on, people want to serve. They want to learn to do that. So let's create the space for people to be able to serve on our Health and Social Care Boards and get that right at the beginning. Succession 11:07
planning needs to be thought about the moment you appoint somebody. The senior executive team's succession planning, I know from talking with our current Permanent Secretary Peter May, this is something he is focused on, something he has focused on 11:07
in relation to the training and development of Non-Executive Directors and that induction piece, that is on his agenda, and he is watching it and he wants that to happen. We need to think of how we make these roles, not just Non-Exec, but the senior executive 11:08
roles, attractive to encourage people to apply because they are incredibly rewarding."

Now, you got a mention in dispatches on that issue, but does that indicate that there is an ongoing dialogue 11:08
around this and the ways in which you jointly can improve this and try to bring further stability around Boards?

A. Yes, I think that's fair. We talked a little bit about

appointment processes, but obviously the more fundamental thing is when people are actually in post and how you work with them. For me, the Board has a central role to play in the accountability mechanism and they're there to both support and challenge the executive team, and they need to determine what the right balance of those two is, depending on the issue and where things are. And I expect and look to Boards, and particularly to Chairs, to raise up to the Department and to me, issues that they feel, you know, their Board are not able to address and are concerned about. 11:08 11:09

I think Eileen is right to say that these are -- Trusts are big and complex organisations. So, you know -- and our risk profile at the moment, for reasons that are not the responsibility of Board members or, indeed, the executive teams, is, you know, it's a lot more loaded than you would really like, because we do have a demand and capacity gap, we do have a very significant resourcing challenge at the moment, and that's likely to continue in '24/'25 at least. And as a result, you know, the risk that something will go wrong in systems that are under very significant pressure is greater. So all the more reason to work with Boards to support them. We do provide a basic induction for all Non-Executives, but in addition to that the leadership centre has put in place a series, a half day course for Non-Executives to invite them to come together from 11:09 11:09 11:09

various health and social care organisations, and I've been to a couple of those events recently to offer a departmental perspective, and I know each Board is being offered a day for its Board to go away and to think about how it operates as a collective, again through the leadership centre, and I think those are good initiatives and ones that we would want to support.

I don't think that those are things that the Department should run itself because, again, that's inviting us to get into the space of trying to tell Boards what they need and what they don't need, and I think this needs to be much more something that Boards themselves determine, and we provide, as I said, the support that is needed and, indeed, the input that's needed to any training they do decide to take forward.

30 Q. And, of course, the Department has a vested interest in Boards operating effectively and being...

A. And as accounting officer I have a particularly vested interest.

31 Q. Yes. And the personnel and the expertise on that. The evidence before the Inquiry, and it's for the Panel to consider that evidence, but there has certainly been a spotlight on the absolute essential nature in the governance train of an effective Board?

A. Yes.

32 Q. So for the Department to have that quality assurance, it would seem that Boards are a particularly

fundamental requirement that that is both properly manned but also properly functioning.

I'll just go to what Maria O'Kane said at her evidence at TRA-11670. And this was around Board composition. 11:11
And I take the point you've said that there has to be a line of demarcation so the Department isn't seen to be, I use the word "interfering" in a neutral way, but getting overly involved in the management of the Trust. But the sentence that has been asked is: 11:12

"Can the Department do anything to assist Trusts in this respect?"

And, again, this is around Board composition. And 11:12
Mrs. O'Kane said:

"It's possible. I know that certainly, you know, the foundation Trust structure in England is different in that there are councils and there are Trust Boards, and 11:12
there's probably a lot more input from the public. But, again, I imagine one of the limitations on this is we are working in a really financially restrictive environment currently and all of these things, obviously, have to be accounted for. But certainly, 11:12
you know, anything at all that can add to the breadth and depth of the expertise and the time allowed to the Non-Executives I think would be welcome."

So there's no particular directed expectation from the Department in Mrs. O'Kane's evidence, but she does raise the resource issue, and one of the issues that came up in evidence in relation to the Board was the remuneration of Board members and how reflective that may be to the time commitment and the level of expertise some of the individuals bring. I just wonder if you have any view in relation to that or is it anticipated that there will be any review of fee structures or does the Department -- what's the Department's view on that issue generally? 11:13 11:13

A. Well, I think firstly I would commend those who put themselves forward to be on Boards for their public service, and I always say that when I meet them. We currently provide three days a week for Chairs and a day a week for Board members. Of course if I see a strong evidence base that suggests that that's inadequate, then we could look at it. We don't currently have plans to look at it. 11:13

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What I would say is that inevitably in a big and complex organisation like a Trust, it would be possible for Non-Executives to spend all of their time on Trust business, and if you end up with full-time Non-Executives I think you then run a risk of blurring the line between what's an Executive and Non-Executive responsibility. So the Non-Executives are there to hold the Executive team to account, to support and challenge them in the work that they do, not to do it 11:14

themselves, and I think that's an important distinction. So I can understand particularly when Board members are newly appointed and they're going through induction, as well as learning lots about the organisation, it may be that, you know, they feel the recognition of that in terms of the time isn't quite right. So there may be things that we should look at there, I don't rule it out, but it's not something that has been -- I've not had representations on this specific in the two years I've been here. I've had representations from Boards and Chairs on a range of other things, but I don't think, you know, this is one that has been particularly strong. I have read and heard the evidence that's been provided, so I recognise there is some sense of a need here. So let's -- by all means, I'm happy to reflect on that. 11:14 11:15 11:15

33 Q. I wonder if we could just finish, or go to another topic before we take a short break? It's Information Systems in Health and Social Care, and it's a short topic, but I'd like to just ask you about some of the improvements that have taken place. If we go to your statement at WIT-107069. The question we asked in your Section 21: 11:15

"What is your view of the importance of enabling a health and social care information system that can be used by organisations to drive improvements in safety, quality and performance, and inform integrated governance at each level of the system? Is such a 11:16

system envisaged? If so, set out the details."

So at paragraph 30 you say:

"The Framework Document 2011 sets out the extant roles and responsibilities and arrangements for discharging same across the Department and health care system." 11:16

Paragraph 31:

"The use of information systems to drive safety, quality and performance operate at a range of different levels and require both ready access to the right data and the ability to combine a variety of datasets to provide a complete picture. For example, in relation to how HSC Trusts are overseen, during 2023-24 the Department tested the use of a Balanced Scorecard approach at the ground clearing meetings which were held in preparation for subsequent accountability meetings with the HSC Trusts. This approach is expected to involve the extraction of pertinent information from a wide range of systems to support a holistic view of Trust performance as part of accountability arrangements across a number of domains, including, for example, performance, safety and quality, patient experience, and productivity and efficiency." 11:16 11:17 11:17

Paragraph 32:

"The Balance Scorecard approach will be evaluated before any decision to embed this as a new process to support departmental accountability arrangements with HSC Trusts." 11:17

So just on the Balance Scorecard approach, is that a new way of bringing in data that allows an overview to be taken in relation to performance and safety and quality? Is that to inform the Department or both the 11:18
Department and the Trust? What's the sense of that?

A. Well, it would be designed -- it would be something, a tool the Department uses, but it would absolutely be something that is visible to the Trusts and the Boards. So there'd be a clarity that that's what we were 11:18
looking at in terms of each of those domains. We actually, as a senior team, had a meeting to discuss, yesterday, the kind of measures that could be introduced against each of those domains, with a view to trying to minimise those, to keep them to a small 11:18
number of really important measures. The risk is always that you can identify 6 or 10 other things that you could usefully measure as well, and then it becomes a very cumbersome process. But if we're clear what we think is really important, that can also help to focus 11:18
Trusts and their Boards on what's important. And as with all of these processes, the data will give you a starting point, but there's also then a need to use the experience that, you know, the Department has of its

engagement with each Trust, to understand, you know, whether that correlates with the experiences that we're seeing.

So your question was whether this was something just for the Department or for the Department and Trusts, and it is for both. But it is something the Department would put in place, because it would be the accountability mechanism that it would use and it would support then, and essentially replace the commissioning process as a result. 11:19

34 Q. Is this anticipated that this is information the Department will interrogate or be curious about so that they can go to the Trust and say "We need a little bit more explanation about what's behind this." I presume from your explanation it's both qualitative and quantitative? 11:19

A. Yes.

35 Q. So is there an expectation -- and the context of the question is in some of the Board information that was received by the Southern Trust Board, there was some suggestion that there was an absence of curiosity to get underneath the data, or underneath the one dimensional lines of information that they were being provided. Is this something, is there learning from that for the Balance Scorecard? 11:20

A. So I don't think -- assurance processes shouldn't be tick box exercises where you get a piece of data and you say "well that's all okay then". As I said, you've

got to correlate that then with the experience that, you know, the organisation, the Department of Health in this case, has multiple interactions with each of the Trusts on a very regular basis. So it's also about understanding those interactions alongside whatever the data is telling you.

36 Q. Given some of the evidence that the Inquiry has heard, is there a sense, from your perspective and your interaction with both this Trust and other Trusts, that the quality of communication has improved, or the ability to question information, is there any sense that there is a greater sense that people are unafraid to raise issues of concern at the earliest point?

A. Well I don't think I can offer a comparative view, because I wasn't here prior to two years ago, but what I would say is that it's been a focus of mine to try to engage with Trusts, both at Executive and Non-Executive level, and the feedback I think suggests that that is succeeding both in individual and at a systemic level. So -- sorry, could you just repeat the question again? I think I'm going off on a tangent.

37 Q. I'll try my best! The context of why I was asking you that is, we've been here as long as you've been in post, we're nearly the same age, I suppose, in that respect. Has there been incremental learning in your position as Permanent Secretary where there is more openness, that there is a sense of learning as we have gone along, that the Department has also gone along in their learning as to how to interrogate Trusts or to

oversee governance, has that been an organic thing?

A. Absolutely. We've certainly been putting time and effort into how we do -- take a helicopter overview of where a Trust is in order that we can understand what support they need and whether there are any interventions the Department can contribute to. And, you know, then where we do identify those then there'll be a more detailed conversation with the Chair, or with the Chief Executive, or with both. I think it's one of those ones where you can never be sure that you've got it completely right, but I think that we have made some good process. I don't, myself, have a sense that there is a reluctance on the part of Trusts to be open with us about problems that they're facing, and I welcome that, and I think that that is an important part of creating the right kind of culture. So, you know, obviously that goes to how we react when we're told that things are not where they need to be in specific areas and how we build together confidence around the plans that the Trust should initially put in place to address those difficulties. 11:22 11:23 11:23 11:23

38 Q. You've also mentioned the Electronic Patient Record system. Obviously our focus is on governance and the way in which some of these systems may assist in improving that. At paragraph 33 you say as follows: 11:24

"Looking at how clinical information is joined up, the successful introduction of the Electronic Patient Record (EPR) at the heart of the Encompass Programme

required a review and standardisation of clinic pathways by health care professionals. Going forward the information from the acute and community care sectors that the EPR makes available will significantly enhance the drive for improvements in safety, quality and performance, and inform integrated governance and will compliment existing data and information systems. The system will provide near real-time data which can be used to benchmark HSC acute care and community care services across Northern Ireland, and with other Epic system users in the UK and worldwide." 11:24 11:24

Now that's clearly an attempt to joined up thinking of data provision around patient information at the point of clinical need, and you've mentioned Encompass, which seems to be quite a significant project. You've mentioned that at paragraph 43. We'll just look at that. 107073. 11:24

So you're explaining the Encompass system. We've asked you specifically to explain the purpose of it, the extent that it has been rolled out, how it functions and how it is intended to benefit health and social care organisations, and staff, and patients and carers, and what is the timescale? And you've provided the following information: 11:25 11:25

"The Encompass Programme is a clinical and operational transformation programme with an Electronic Patient

Record solution supplied by Epic at its heart. Northern Ireland is the first system to adopt this unified approach to an electronic health record at integrated care system level and is the first in the UK to incorporate social care as part of this endeavour. It is the largest implementation of the Epic platform in Europe.

The flagship programme will see Encompass replace or link with the vast majority of clinical systems currently in operation in acute and community care settings, replacing existing often end-of-life Patient Administration Systems and clinical record systems across HSC NI. The EPR will provide those working in acute and community care with a single holistic, appropriate view of a patient or service users' interaction with those sectors. Primary care professionals will also have appropriate access to the information."

11:26

I wouldn't want to put Encompass in a nutshell because it does seem incredibly complex, but is this a way of trying to get everything that's relevant and necessary clinically about people together in one spot so that they can be accessed by the relevant primary care professionals at the point of need? Is that at least one aspect of it?

A. Yes. I mean Encompass is probably the largest single change programme that health and social care has

undertaken because it requires everybody who has contact with individual patients to do things radically differently to the way they would have done them before. And as a result, as with any major change, you will find that there is a spectrum of views about how easy or otherwise it is to use that system. But I was talking to the Chief Executive of the South Eastern Trust, which is the Trust that has already gone live recently. She was identifying clear benefits in relation to patient safety, in relation to patient experience, and in relation to efficiency in a range of different ways. So we've got more to do because there's still a few teething challenges, as you often find with the introductions of new systems, but I am confident that the Encompass system will be a big step forward, particularly assisting actually the safety and quality agenda, and I think that's been the experience elsewhere of where it has been brought in. 11:27 11:27 11:28

39 Q. And the rollout of Encompass involves training all of the staff on that I presume? 11:28

A. Yes.

40 Q. What's the sort of timeframe for that? Is there an end date for final integration?

A. Do you mean when will it be rolled out across all of the Trusts? So our current target is that by this time next year all the Trusts will have gone live with Encompass. The Belfast Trust will go live in June, the Northern Trust in November, and then the Southern and Western Trusts are March/April next year. That's 11:28

obviously subject to readiness assessments which are detailed in relation to each of the Trusts, but that's the programme, and I think that may be set out elsewhere in the statement.

41 Q. And given that the expectation that Encompass will help the health and social care in Northern Ireland work more effectively and efficiently through regional standardisation based on best practice, which is from your statement, it's anticipated that one of the wins of Encompass as well as the efficiency will be better governance? 11:29 11:29

A. Yes. So as I said, there's a big safety and quality dimension here. By creating agreed pathways, pathways that are set by the clinicians in each speciality for how conditions will be managed, you should remove unwarranted variation from the system. You are reducing the likelihood or the risk of medication being done in a way that's not appropriate, you are increasing the ability of patients to track their own engagement through the My Care portal, the patient portal. And, as I said, in addition, there should be some efficiency benefits. The other way in which the patient experience is improving, and the fundamental way, is that they should only be telling their story once and then every clinician can come and see what that story is, rather than having to ask the same set of questions, and anyone who has been had in a health and social care setting will know that that's a big challenge. 11:29 11:30

42 Q. And the Inquiry has heard evidence that in this jurisdiction patients don't automatically or routinely get letters about their care from hospitals, it's usually sent to the GP. There is some individual practice that it does happen, but there's no uniform policy or standardised approach in relation to that. Is Encompass a way in which people could access a section of that to find out if they have been referred for tests or if a letter has been sent to the GP and, indeed, what it says? 11:30

A. So, certainly I think it could do some of that, it may not do all of it. I think things like the discharge letter, if you're leaving hospital, then that would be available to you on the My Care portal. You would be able to access the results of some tests at least. I think though, importantly, we shouldn't forget that there is a human dimension to some aspects of this, so there are some tests that you wouldn't want to be telling people the answer by them going on to an app to find the result. So, you know, I don't think -- I think we just need to make sure that we have a nuanced view of how that patient portal will work in practice.

Similarly, the language used by some consultants, at least in writing to GPs, wouldn't be accessible to members of the public, so we just need to make sure that what's being made available to members of the public is stuff that we can reasonably expect them to be able to use and make use of sensibly.

43 Q. And, indeed, a lot of members of the public may not have access to the technology to be able to...

A. Well, I think that's a relatively small number now, and a decreasing number, but I accept that there will be cohorts that that applies to. 11:32

44 Q. Chair, I wonder if that is a convenient time?

CHAIR: Yes. We'll take a short break and come back in 15 minutes time, which if I've worked it out is ten to twelve.

11:32

THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

MS. McMAHON: Mr. May, I wonder if we could move on to some of the issues of reform and reviews that you've mentioned in your Section 21, and if we go to your statement at WIT-107116, at paragraph 178. Now this is in relation to the reform of maintaining high professional standards, and you say: 11:49 11:49

"A review of MHPS commenced within the Department in 2023 with the establishment of an independent review panel under the direction of the MHPS Review Steering Group. The Panel consists of three individuals who are external to the Department of Health, HSC NI. Each bring differing expertise to the project covering operational experience of the MHPS framework, medical leadership, governance, employment law, rights, 11:50

knowledge, and restorative just and learning practices."

And then you give us an update at paragraph 179. If you could just move down to 181, please? And in relation to the outcome of the review of MHPS you say at paragraph 181:

"An initial working draft report will be produced and presented to the Steering Group by the end of March 2024. This will contain the review panel's initial key findings and recommendations on the way forward for MHPS within the HSC. It is hoped the final report will then be presented to the Department by June 2024."

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And you say can a copy can then be shared with the Inquiry once published. Just in relation to those timeframes, where are we at the moment?

A. The Panel met the Steering Group at the end of March and made a presentation rather than offering an initial draft report. I'm not on the Steering Group, but the presentation covered, I think, the main areas. I had met the Steering Group a few weeks before that just to understand where they were, and my understanding is that their key finding is essentially to say they're not clear, they don't believe there should be a separate process for managing standards for doctors compared to other employees for health and social care, other practitioners, so I haven't seen the detailed

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outworking of that yet, and they're going to develop that into the report. We are still anticipating receiving that report by the end of June, and I'm conscious that it is part of the Inquiry's Terms of Reference, so we would be keen to engage and share that with the Inquiry, not least to understand if the Inquiry has any views on it. I recognise that in timeframe terms there could be a tension here, because the Inquiry report is likely to be some way off, with the best will in the world, but we may -- if the -- if there was some way, and perhaps more informally, of discovering whether the Inquiry felt that was the right direction of travel, that might be extremely useful to us, because I don't think the Inquiry would want us not to start doing anything on MHPS until after the Inquiry report is published. So we might just need to have an engagement about how that would work in practice.

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CHAIR: There should be no difficulty with that, Mr. May. There should be no difficulty with some sort of engagement once we see the report.

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A. Thank you.

45 Q. MS. McMAHON: Just for the Panel's note when they're looking at the evidence again. Maria O'Kane's evidence on this issue can be found at TRA-11730, where she says:

11:53

"The Trust was asked to give feedback to the Department on their MHPS review and they offered suggestions."

Also at TRU-306519, there was a review of the MHPS stakeholder engagement questionnaire and the extent to which that was fed into the review. So that's -- the update on MHPS, then there was a review of SAI procedure, and you deal with this at WIT-107117, at paragraph 183, and I think we're actually on that page. Yes. So you say: 11:53

"A redesign of the current Serious Adverse Incident (SAI) procedure is progressing led by the Department. This will result in a new framework replacing the current SAI procedure. SPPG and HSC Trusts, amongst a range of other partners, sit on the programme Board Redesign Development Group." 11:54

And then at 184: 11:54

"The programme of work will seek to address relevant recommendations arising from the IHRD..." 11:54

-- which is the Hyponatraemia Inquiry, and the Neurology, INI Neurology Inquiry,

"...alongside recommendations from the RQIA review of systems and processes for learning from SAIs, which together have provided a clear and strong evidence base underpinning the need to fresh and redesign the current approach to learning following SAIs." 11:54

185:

"The SAI Redesign Programme is being progressed by a redesign working group and a redesign development group. Membership of these groups comprises senior colleagues from the Department and from the HSC, including Trusts. This programme of work will introduce a new framework to deliver learning and improvement from patient safety incidents events through a new streamlined and simpler review process. The Departmental work will not focus on reviewing and refreshing all local systems across HSC Trusts and delivery areas, rather it will deliver a clear overarching regional framework together with supporting methodologies, learning and improvement tools, and relevant guidance."

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CHAIR: Sorry, Ms. McMahon, I hesitate to interrupt you, but there seems to be a drone. I don't know if that's internal or external.

11:55

MS. McMAHON: I thought that was just local to me.

CHAIR: No, definitely not you, Ms. McMahon.

MS. McMAHON: I can hear it as well.

CHAIR: I don't know if it's inside this chamber or whether it's something happening outside. Can I just ask PI-communications if they would check the equipment isn't creating it in any way. It seems to have stopped.

11:56

MS. McMAHON: It does. It stopped when I stopped

speaking, but I won't take any correlation to that droning. I'll go back. If that's okay, I'll go back and it's paragraph 188.

"It is anticipated the new framework will deliver a fundamental change in how HSC organisations review and learn from patient safety incidents resulting in improved care. The new framework and supporting guidance will be less detailed and prescriptive in many aspects in contrast to the current SAI procedure." 11:56

Then you set out at paragraph 189 the areas of key focus for the current phase of the SAI redesign work, which include:

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"Further involvement and co-production activity with both patients, families and staff, and wider stakeholders, to seek views and to build confidence in emerging proposals.

Redefine and rebalance the oversight and assurance functions, local and regional, as part of the new framework and how these will work in practice. 11:57

Achieve correct balance between greater organisational autonomy and flexibility and redefined organisation and regional oversight and assurance roles. 11:57

Further drafting of the new framework in supporting guidance.

Opportunities for managed prototyping aspects of the emerging framework and planning to deliver a managed

transition to a new framework.
The policy team is targeting a consultation on the new framework in autumn 2024."

Now, I think you mentioned from a section I read just a moment ago that there had been information gathering or suggestions or advice sought from other key stakeholders in relation to this. The Inquiry heard evidence from the Chief Executive of the Patient and Client Council, they had undertaken a specific piece of work around the voices of patients and service users and the way in which they experience the SAI process, and they gave - Ms. Monaghan gave detailed information about the way in which some people were dissatisfied about the process, and I'm sure that's not a surprise to you that there are considerable flaws perceived or in reality from both clinicians who have to inform the process, but also end users whose experience perhaps is used as a basis for an investigation. So, is it anticipated for the Inquiry's purposes around governance that this new framework will result in better outcomes for all of those stakeholders in the SAI process and also tighten up aspects of governance that are arguably absent in the current process?

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A. I think the obvious thing to say is if it doesn't achieve that, given the shortcomings that have been identified, as you say, in various sectors, then it won't have achieved what it set out to do. So, as with -- and I think similarly to MHPS, the delivery of the

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report or the outcome is one thing, implementing it well is actually a bigger and more important task. And often it's not the words on the page that are the problem, it's the way those words are interpreted within organisations or in the way processes work. 11:59

I think SAIs, it is also fair to say, there will -- we should not imagine that there'll be a world in which everybody is always happy with everything, and SAIs I think is particularly one of those areas. The purpose 11:59
of SAIs is to produce learning, and in particular learning for the organisation for the individuals, learning for the system. There will be people, including potentially those who have been affected by incidents, who have a different focus as they approach 12:00
an investigation and see it as an investigation rather than as a learning exercise, and that will be -- it will be really important to try and be clear what SAIs do and don't do, and at the moment I think there's a risk that people -- there's a kind of obscuring of that 12:00
in people's minds.

So I suppose I'm saying that with a view to conditioning expectations about what will and won't be possible through a review of SAIs. But you are right 12:00
also to draw out that the review should also improve the speed in which the SAI takes place, the way in which learning is disseminated, and in particular how, for example, learning is identified, including from

multiple SAIs, and there's an important role for the Department through SPPG and the Public Health Agency in trying to look at those systemic lessons and draw those out. So those are all things I think it's reasonable to expect that should happen, and it should improve people's experience in a number of ways. As I said, I just think we need to be careful not to assume it will make everybody happy all of the time, because that probably won't be the case.

46 Q. I think to be fair to the witnesses who gave evidence on this issue, there was a recognition that at times there was a mismatch of expectations what SAIs were meant to do and what they could do and what people thought they might do? 12:01

A. Yes. 12:01

47 Q. So there was -- as you've said, hopefully there will be some clarity gained with the new framework document. We had asked you about other developments, in particular a review of Early Alerts, and you say -- just if we move down to paragraph 192. Sorry, my mistake, 191, and you say: 12:01

"On 15th November 2022..."

-- which is when you last gave evidence: 12:02

"I committed to a review of the Early Alert system when giving evidence at the Urology Inquiry."

And then you give us the evidence that you gave. If we move down to the next paragraph, at 192 you indicate that:

"Due to resourcing pressures this work has not yet substantively commenced although some early planning has taken place. It is currently anticipated that a review of the Early Alerts process will be undertaken by the Department in 2024." 12:02

12:02

Is this again just an example of competing priorities around what can be done and what needs to be done more urgently?

A. Yes, essentially it's a prioritisation exercise. I hope that the Early Alerts will be a less major piece of work than SAIs, and I think it is realistic to expect that that is the case. But I'm also conscious that not only are the team that will be taking this forward leading on a number of the areas that we've already talked about, but they also are likely to be drawn into supporting the Covid Inquiry quite substantially due to other tasks they took on during that period. So it is just a question of balancing and making sure that we are able to deliver on the targets that we set ourselves. 12:02 12:03 12:03

48 Q. Again on the Lookback Guidance Review at 193. If we go to 195. It had been anticipated there would be a review of this, and you say at 195:

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

Again is that for the same reasons you've just outlined? 12:03

A. Yes.

49 Q. If we go to 196, in relation to reforms and action that has been taken and move forward, you say at 196:

12:03

"In February 2023, the Department commissioned the Getting It Right First Time team to complete a review into Urology services. One of the key reasons for undertaking this review was to ensure that recommendations could be identified and implemented at 12:04 the earliest possible opportunity to facilitate the improvement in the extensive waiting lists in this area and to ensure that patients are treated as quickly as possible to ensure best possible outcomes."

12:04

Then we move to 199, the outcome of this Getting It Right First Time Report, and you say:

"The report has identified a series of 40 recommendations to improve the service in addition to a 12:04 list of recommendations for each HSC Trust. These recommendations have been accepted in principle by the Department. Work is already underway on many of the recommendations. However, others will require funding

and resources. The recommendations focus on the themes of maximising surgical assessment, diagnostic capacity, and improving efficiency, strengthening pathways and protocols, exploring non-consultant grade skills mix and training and regionalisation of services. Funding requirements have yet to be fully quantified but will include investment in the workforce, which includes creation of additional posts and training of staff, along with capital funding for equipment and infrastructure." 12:05

Now, the Inquiry has had sight of that documentation, but for their note, the Recommendation Action Plan dated 6th March 2024 is at TRU-306468, and when one looks at the Action Plan, and the recommendations and the RAG that they have applied to it, the red, amber green way of designating priority for recommendations, quite a significant amount of work appears to have been done on what can be done at this instance, but it's clear that the Department has a role in relation to funding and some oversight in relation to improvements in that respect. The updated position on that, is there any movement forward? Does the Department envisage any extra capital raising for the implementation for those particular recommendations? 12:05 12:06 12:06

A. So, for the purpose of the '24/25 year, we're still waiting for the budget outcome as things stand. I mentioned earlier that that budget outcome looks as though it's going to be very constrained, and the

ability to do new things may well not be easy. So I don't want to prejudge the outcome of that. But I did get -- I did have a meeting with the team in the Department who are leading this work, and they did say that there was a strong clinical buy-in to the recommendations that is have come forward from the GIRFT Review, and real momentum in terms of taking the actions that we can take. So they were clear that they thought it would be possible to make progress in most of the areas, in pretty much of the areas set out. There may be limits to how far they can go, in the absence of new money, but they can at least start the work in a range of those areas. So that I think was, for me, a positive signal, both in terms of orientation and of progress, and we will be issuing a progress report formally, probably in the summer, as to where we've got to against each of the recommendations. 12:07 12:07 12:07

50 Q. You've mentioned about the restriction in capital and the difficulties then that will be faced by constrained budget. When Mrs. O'Kane gave evidence, she gave us an example certain audit and tracking functions that had been funded by the Trust at risk, which she had said they yielded real on the ground improvements in some of the areas where harm was in the past caused, and as a result of that they have seen significant improvement are. And for the Panel's note that is Mrs. O'Kane's evidence at TRA-11742 line 6 to TRA-11744 line 16. Now, the nature of the functions of the audit and tracking functions that she had identified, didn't seem 12:07 12:08

to face some of the major hurdles and obstacles of other requirements, such accessing nurses and doctors and requiring significant funding, and they were more about filling in of admin roles and reconfiguration that the Trust had funded at risk. Given the identification by Mrs. O'Kane that those sort of changes yielded real on the ground improvements in areas where harm had been caused in the past, is that something the Department might consider funding going forward rather than on an at risk basis by the Trust? 12:08 12:09

A. I'll come to the specifics in a moment, if I may, but just perhaps at the risk of repeating myself go back to, you know, the Trusts are given large budgets, and I think it is for them to determine where their priorities should be. Clearly if we want to commission new services then there should be an expectation that with new services comes additional funding. 12:09

In relation to urology, I think the Southern Trust has seen quite a significant investment in urology services in recent years, around 2.9 million over a number of years. In relation to the specific administrative functions, my understanding is that in 2019 there were three of these roles that were being funded. Through SPPG that's now increased to 11. Obviously I'm not cited on whether the Southern Trust has more than 11 people in post or not, and I think that's getting to a level of detail that probably isn't where I would want to be anyway, but it's just to signal that there was a 12:09 12:10

recurrent investment of about 180,000, I don't have the precise number, over to support those additional administrative roles in the area that you describe.

51 Q. And when you mention around the issue of money, and it's not always about money it's the way the money is allocated as well, rather than just the amounts, that was something that was given in evidence by Sharon Gallagher of SPPG, and we don't need to go to this but I'll just read this out for the Panel's out at TRA-11015. Ms Gallagher said: 12:10 12:11

"We are in a demand capacity deficit. Waiting lists in Northern Ireland are longer than anywhere else in England, Scotland or Wales, and that is something that as a senior team in the Department we pay huge attention to. Over 50% of the block grant is allocated to health, so around £7 billion a year is allocated to health." 12:11

She also said: 12:11

"It is a matter of public record that no service is currently achieving or receiving the funding that is required to meet the deficit, and in that regard it is really important that we provide safe services because the provision of them or access does not come at a premium to safe services." 12:11

And in relation to urology, we have mentioned the

funding that has been allocated there. Mr. Cavanagh in his evidence says at TRA-11017:

"I think only one other acute speciality has received more funding in the last 15 years than urology." 12:12

So that's to tie in their evidence. There has been a lot of mention of culture and changing cultures in the Trusts, both in relation to the individuals feeling safe enough to raise issues, but also for others to 12:12 feeling confident enough to ask questions, and people to highlight issues in the first place. What do you consider is the role of the Department in assisting Trusts around the culture regarding governance to ensure that there is an environment in which anything 12:12 touching upon patient quality or risk does find it's way to the right ears and that change is effected?

A. I think the Department is responsible for setting the overarching policy and strategic agenda for developing detailed frameworks that may be needed to support that, 12:13 and then for seeking assurance from the Trusts as to the extent to which they have been able to meet the terms of those policies and frameworks that are put in place. So to use an example, we've employed an independent expert, Peter McBride, to lead some work on 12:13 a Being Open framework for HSC, and he's done that initially at the request of Belfast, starting in Belfast, because of the challenges they faced in the Neurology Inquiry, and then the Southern Trust, again

at the request of the Chief Executive. He is now working with the other Trusts also to engage clinicians about what is needed in such a framework? What is it that is stopping people from coming forward and raising concerns? How do we get to a place where being open is the norm and not just when things have gone wrong? In other words, it's an all of the time piece. And he's developing that framework at the moment, and I hope that will be available fairly shortly. And, again, would be a task around how that is then implemented and brought about. 12:14 12:14

But culture is absolutely the heart of all of the work here, and something that I and the team in the Department are really focused on as to how do we develop the right kind of culture, both in terms of how the sorts of examples that you've raised about people being willing to raise concerns, but also in terms of the engagement we have with our -- all of our arms length bodies as well. 12:14

52 Q. And I think you've written to the Boards recently in September, 23rd September 2023, around the HSC Board Member Handbook, emphasising, re-emphasising the importance of the existing responsibilities and other policies that applied, and for the Panel's note, that's referenced in Mr. May's statement at WIT-107103, paragraph 137. And you've kindly provided a copy of that letter which can be found at WIT-107560, and the following three pages from that. 12:15

A. I think one of the useful things about that handbook was that it had quite a long section towards the back giving some case studies that tried to draw out how the kinds of concerns that might find their way to a Board, what is the kind of checklist of things that you may then want to, a Board member may want to consider and look at, and I thought that was something -- it was done before my time originally, but I thought that was a really good part of the handbook. It wasn't just a long list of things you should do, it tried to make it something that had been applied in a way that would be useful to Board members. 12:15 12:16

53 Q. Now in relation to driving change, you've highlighted some of the areas of developments in your statement, and if we go to paragraph 90, WIT-107086. Sorry, 107087. Where you mention the HSC Performance and Transformation Executive Board, and you say: 12:16

"It brings together leaders from across the health and care system to bring a collective approach to driving change. The Expert Clinical Panel (ECP) brings together senior clinicians to collectively consider key transformation initiatives. There is also an ongoing commitment within the Health and Social Care Workforce Strategy 2026 to continue to align and support a collective leadership culture within the HSC through the full implementation of the HSC collective leadership strategy. This action is the responsibility of HSC employers. HSC Trusts devote resources to 12:16 12:17

learning and development, which include support and training for staff taking on leadership roles."

So, is that a further way in which people with the right information and the right knowledge and experience can come together to help transform care where that's needed? 12:17

A. Yes. I think somewhere else in the statement we had set out that the three different groups at overarching strategic level, the Performance and Transformation Executive Board, the Expert Clinical Panel that's co-Chaired by the Chief Medical Officer or the Chief Nursing Officer, and then the ITAB, the Independent Transformation Advisory Board, that brings in some people within health and social care, but also representatives from outside, including from some business in third sector organisations as well. And that's the kind of overarching strategic frame. And then within -- under that there are a set of detailed programmes, of which the Workforce Strategy would be one. 12:17 12:18 12:18

54 Q. And you mention the Workforce Strategy in the next paragraph. If we just move down to 91?

"The Department's ambitions for the development and Health and Social Care Workforce are outlined in the Health and Social Care Workforce Strategy 2026 Delivering For Our People, which was published in May 2018. This was in response to a recommendation in 12:18

Health and Well-Being 2026 Delivering Together. The outworking of the expert panel led by Professor Rafael Bengoa, tasked with considering the best configuration of health and social care services in Northern Ireland."

And then you go on to explain the way in which the strategy was developed. Now we're closer to 2026, the timeframe mentioned. What's the position in relation to this particular strategy at the moment? 12:19

A. So there has been a lot of work undertaken. I think there are -- there are still major challenges in relation to workforce in health and social care. There is no doubt at the time this was written in 2018, no one was predicting the pandemic, and that has obviously 12:19 materially impacted on the experience of the workforce in work and something that has required some adaptation.

The headline figures show that since 2018 there have 12:19 been really significant increases in all areas of workforce, including all of the major health professional areas. I think it's around 18% for doctors, and over 15% for nurses and allied health professionals. So there has been major investment, but 12:20 we know that there remain real challenges within the workforce, and you've referenced already on a number of occasions the demand and capacity gap, and that is absolutely driving this, because it means that people

are working really hard every day, but at the end of the day their workload is either the same or greater than it's ever been as a result of that demand not being met. So we aren't unique in facing those problems. They are and feel really acute for our region, and it is something that we are all working as hard as we can to resolve. But we are also facing constraints. And so it does feel sometimes as though, you know, you're trying to deliver that change with your hands tied behind your back because you don't have the wherewithal in order to make the investments that are going to be needed in a variety of areas that will make the change that's needed. 12:20 12:20

Not all of that investment -- I know this Inquiry has focused on urology, which is a hospital based service, but not all of that investment is needed in the acute sector and there's actually a need, a particular need to invest in primary care and in social care in order to stabilise those sectors and in order to ensure that they are able to deliver the maximum that they can do in order that that can assist the acute sector. 12:21 12:21

55 Q. And you've provided a breakdown of some of the figures in relation to staff retention across the HSC in your addendum statement. For the Panel's note, that is WIT-107634, and relevant paragraphs are 45 to 48. At paragraph 48 you say: 12:21

"All staff groups have seen a decrease in vacancies

actively being recruited since 31st December 2022. At 31st December 2023, there were 5,906 vacancies actively being recruited across health and social care in Northern Ireland. This equated to a vacancy rate of 7% and was a decrease of 2,410 vacancies since the serious high point at 31st December 2022, which was 8,316. The total number of vacancies under active recruitment at 31st December 2023 is 29% lower than at 31st December 2022, and 18.4% lower than at 31st December 2018." 12:22

12:22

So that gives the Panel a snapshot of some of the challenges faced in both recruitment and retaining staff.

Now there has been movement in the development of new roles, advanced practice roles? 12:23

A. Yes.

56 Q. Has that been as a result of demand from the Trust, or is that led by the Department, or is it a match of both? 12:23

A. Well in principle it should be led from within Trusts on the basis that, you know, that they identify the need. I think the Department does have a role to play both obviously in terms of the commissioning of the training needed, but also in terms of drawing out whether it is best practice from other jurisdictions that could apply to our region to help with that, and I know in the context of advanced nurse practitioners, the Chief Nursing Officer, Maria McIlgorm has been a 12:23

really strong advocate of that and trying to demonstrate and help Trusts to understand where those roles can really add maximum value, often being able to perform functions that are currently undertaken by consultants who could then be freed up to do other even higher value work as a result.

57 Q. And is that -- are they posts that would be expected to be funded from existing budgets rather than there being any capacity to provide additional monies?

A. So there's two aspects to this. There's a training cost, and training costs would be met predominantly by the Department for all training pre-graduate and post-graduate training. There may be areas where there is a sharing of cost, and if a Trust identified a need to go and, you know, really develop this in a big way, you know, there may well be constraints as to what we could afford to deliver. 12:24

In terms of then appointing somebody at the end of it, then it would be for the Trusts to identify the role there. You wouldn't necessarily expect that the ANP would be an entirely new role, and you would expect that they might be surplanting some of the work of a doctor, for example, or existing nursing staff. So it's not necessarily all additional. I think we need to guard against the sense that any idea always has to have a check that goes with it, because that I think then reduces people's innovation, and particularly in the current climate will make it harder to make the 12:24 12:24 12:25

kind of changes that we need to make.

58 Q. Now, you've mentioned that this transformation around the way in which workforce is used, not just new ideas around it, the way in which the specialist skills of people are identified and focused where they're needed, 12:25 that that might help increase capacity, with the capability of retaining people, because there is a pathway through which people may move from a career perspective.

12:26

One of the things that the Department has identified, and you say this at paragraph 109:

"A lack of exposure of training grade doctors to HSC Trusts outside of Belfast can impact negatively on 12:26 recruitment to the substantive consultant posts in these locations."

Was that something that just was organically discovered, that the failure -- people weren't 12:26 attracted to working outside Belfast because they hadn't been sent there as part of their placements?

A. It's a case that has been made by a number the Trusts, in particular the Chief Executive of the Western Trust, has made that argument strongly and, you know, we do 12:26 want to take a look at how our training grade doctors are distributed. We need to make sure we get the right balance here, because they are training grade doctors so they need to be going into roles that will give them

the experience they need to enable them to develop, but that ought to be possible in a range of locations. So, I wouldn't want to suggest that it's only Belfast that has training grade doctors, because that's not the case, but we will look at whether we've got the distribution right and we'll work closely with our doctor training agents in order to achieve that.

59 Q. Does that in some way also dove-tail slightly into the hospital reconfiguration blueprint that you mention at paragraph 29, where it will describe Northern Ireland hospital system and emphasise the importance of viewing it as an integrated hospital network, is that a way of getting away, I suppose, from what we in Northern Ireland might see as different Board areas, and where people may have to go for treatment, is it more seeing it as holistic service provider and focusing on where people are best placed to access health care?

A. Yes. I mean it's looking at how we -- we have done a lot to develop centres of excellence through day procedure centres, elective overnight centres, and rapid diagnostic centres, and those are showing good benefits now. So for the last six quarters our treatment waiting times have reduced, and that is a positive, but we have still got a long way to go, and we need to build on that. So how do we maximise the use of those centres of excellence? How do we draw on the speciality reviews? So there was a review of general surgery conducted in I think 2022, and that made various findings about the standards that needed

to be applied in hospitals, and as a result there has been some quite significant changes to how general surgery is delivered across the region to meet the safety and quality standards that are required, and often in response to challenges recruiting staff. And then within -- at a more granular level, one of the things that the GIRFT Urology Review drew out was the importance of, even within specialties, having centres of excellence and not expecting all our procedures to be conducted in each Trust or in each hospital. So that's something that is being looked at and taken forward in the implementation of that, which you referred to earlier. 12:29 12:29

The final point perhaps to make in relation to the blueprint and the network is that there's also logically a consequence for how we would see our clinical workforce as well. So in principle the clinical workforce can work in more than one Trust and in more than one hospital, but often in practice that doesn't happen that much. Whereas, you know, I think in order to meet the networked ambition, that's something that we do need to look at in more detail. 12:29 12:29

60 Q. The blueprint, is there a timeframe, or is this the very early stages of the evolution of the way in which service may be delivered in Northern Ireland and, indeed, the way people may view Northern Ireland health care service provision? 12:30

A. The work is well developed in terms of the blueprint

and a kind of summary document that tries to draw out the conclusions, and we're currently engaging with our minister about how we would like to take the next steps of that forward.

61 Q. You've mentioned some of the other developments, and we've talked about those earlier. Just for the Panel's note, the Department has also completed strategies and service reviews in a range of areas which set out clear plans for the future, these include published cancer and mental health strategies as well as the review of urgent and emergency care services in Northern Ireland and the Elective Care Framework. That framework can be found at WIT-51386 to WIT-51461. 12:30 12:30

Now the Elective Framework was published in June 2021, and sets the direction of travel, as you say in your statement, as to how change would be brought about to improve elective capacity and capability and reduce waiting lists, and you say at paragraph 129: 12:31

"The Inquiry will be aware from my earlier answers that progress has continued to be made against the actions in that framework with the most recent update being published February 2024." 12:31

You go on to say in that paragraph, and you've mentioned this before:

"The elective capacity has been enhanced by the

development of elective care centres, two rapid diagnostic care centres at Whiteabbey and South Tyrone Hospitals, and megaclinics have been introduced to maximise patient throughput. There has also been service reviews in general surgery, orthopaedics, urology and gynaecology. Work to date has delivered results with the overall treatment waiting lists reduced by over 12% in the 12 months ending 30th December 2023, with six quarters in a row with reducing lists. Our longest list, general surgery and orthopaedics, have been reduced by 20.8% and 7.6% respectively between December 2022 and December 2023. The scale of the problem is significant, but transformative work and recurrent investment would go a long way to address some of the core issues within the system. This transformation work sits alongside ongoing performance management and monitoring of achievement against HSC service delivery planned targets which were set for 2023/2024." 12:32 12:32 12:32

12:33

A lot of the evidence before the Inquiry has been around waiting lists, waiting times, the difficulty in delays people face in accessing services and, indeed, some of the documentation would seem to have set a pattern of escalation clearly from 2010 waiting lists, and the numbers that were being concerned about then by clinicians and managers almost seem like halycon days when we look at some of the waiting list figures now, and even during the tenure of this Inquiry there 12:33

have been many press stories around waiting lists and the way in which the service arguably is unable to cope with the demand and capacity issues. The word "crisis" has been used for the health sector quite a few times in the Trust, in the press, and do you -- is it something that you would accept is the health system in Northern Ireland in crisis? 12:34

A. So everyone can chose their own language. I would say that all parts of our system are under very severe pressure and, you know, there are major challenges in terms of being able to deliver the kind of health and social care system that all of the people who work in that system want to be able to deliver and to be proud of. There are -- we are at a stage where the scale of those problems means there are no quick answers, but the risk, as I see it, is that the current budgetary constraints actually risk making the situation worse rather than enabling the work to be done that would make it better. 12:34

62 Q. Could you expand on that a little bit more, why that's the case? 12:35

A. Well, as I explained on a couple of occasions already, you know, the risk is that the budget will not be sufficient to enable the existing work to continue, there may need to be reductions in service in some areas, obviously depending on the outcome of that budget, let alone actually moving to put in place the transformation that's going to be needed across all of the areas. I've mentioned primary care and social 12:35

care, as well as a focus on waiting lists and the acute sector as well.

63 Q. I just want to finish up on the issue of the learning from previous inquiries, and hopefully from this Inquiry, and you've very helpfully provided an update in your addendum statement at WIT-107628. And for the Panel's note it's paragraph 17 to paragraph 44. I'd just like to read some of this out to give a flavour of the current framework around the way in which the Department manages information that they've received from these various Inquiry recommendations and what's anticipated they will do with that information. And this part of your statement is entitled: 12:35 12:36

"The Department's progress on implementing recommendations from previous public inquiries." 12:36

At paragraph 17 you say:

"In April 2023, the Department agreed to formally amalgamate the Hyponatraemia related deaths and independent Neurology Inquiry Programme Management Boards into a single Department of Health Inquiries Implementation Programme Management Board..." 12:36

12:36

And you have attached a copy of the Terms of Reference. Then you've set out what these, the reasons behind this, and the commonalties and the potential benefits of amalgamating these issues. Sorry, the

recommendations from both of those inquiries.
And at paragraph 19 you say:

"The first meeting of the IIPMB took place on 21st April 2023. The IIPMB Terms of Reference will be kept under review and will be refined and revised as appropriate." 12:37

At paragraph 20 you say:

12:37

"The IIPMB will also explore, if appropriate, how best to bring oversight of the implementation of recommendations from other public inquiries, such as the Infected Blood Inquiry, Urology Services Inquiry and Muckamore Abbey Hospital Inquiry, under the scope of IIPMB in due course. The importance of integrating the implementation workstreams being progressed by external delivery partners is recognised by the Department. This includes engagement and collaborative working between the Department, the health care organisations, the General Medical Council and the independent sector organisations as well as partnership working with other relevant organisations." 12:37

Just on that particular point. Is there an understanding and perhaps a broad commitment from the Department that should it need to bring in other sources of expertise to help bring about the recommendations from this and other inquiries, that 12:38

it's prepared to do so? For example, in the RHI, the Audit Office was responsible in some respects from overseeing the outworking of those recommendations because of the nature, obviously, of the recommendations, but is there a recognition that there may be some cross-fertilisation of oversight needed to bring home these different recommendations? 12:38

A. Yes, absolutely. I think there's a number of different dimensions, and perhaps I could just briefly break them out. So in relation to taking forward individual recommendations, there may well be the need for external input in the way that we've described already in terms of MHPS and SAIs and there being open framework. Those are all good examples where there are external people who are playing a leading role in taking that work forward to assist the Department. 12:39 12:39

The second is, in terms of oversight, what we've done through the Integrated Programme Board that you've highlighted here, is we've introduced, in addition to a Steering Group that I Chair, there is a panel led by and exclusively populated by people who are not in health and social care, who are providing an assurance role as to whether or not a recommendation properly is signed off or not. So it's not us signing off a recommendation saying that's okay without -- so it goes through an assurance panel and the assurance panel look at it, there's a very detailed approach taken to ensure that not only the words on the page have been done, but 12:39 12:39

the spirit under-pinning it is in place, and then that will come forward to the Steering Group with that imprimatur on it. So just to be clear, there's also a service user group that also looks at those elements of the work, particularly in relation to the Neurology Inquiry. 12:40

It's my expectation, obviously you haven't written or let alone us having sight of the report yet, but it's my expectation that this Inquiry will raise some themes that are very similar to INI in particular, and that, therefore, integrating the implementation into the one place will be the most sensible thing to do because, you know, this Inquiry is in arguably a more challenging place in that work is already proceeding as a result of other inquiries having taken place. So part of what may well come out of this Inquiry is a sense of whether the direction of travel that is already in place is the right one or not. And insofar as it is, you know, hopefully that will put wind in the sails of what needs to be done, and insofar as it isn't, then it allows for corrective action to be taken. 12:40 12:40 12:41

64 Q. We haven't touched on everything in your statement, but the Inquiry has all of the information you've provided to update them, so thank you for that. I don't have any further questions for you. Is there anything -- I know you made some comments at the beginning of your evidence, but is there anything else you wish to add at 12:41

this point, anything further to say?
A. No, I don't think so. Thank you.
MS. McMAHON: Thank you. The Panel will have some questions for you.
CHAIR: Thank you, Ms. McMahon. Thank you, Mr. May. Just a few questions from us, first of all from Mr. Hanbury. 12:41

MR. MAY WAS QUESTIONED BY THE PANEL AS FOLLOWS:

12:41

MR. HANBURY: Thank you, Mr. May for your evidence. You'll be pleased to hear that Ms. McMahon has already asked a good few of them. Starting off with GIRFT, we've mentioned this already before.
A. Yes. 12:42
65 Q. MR. HANBURY: And you mentioned there was good buy-in from the clinicians, which is excellent to hear. And we've already heard about in particular sub-specialisation, where Southern Trust are taking on the complex stones, and Western seems to be taking on penile surgery and this kind of thing, although that might have been going on before. 12:42
A. Yes.
66 Q. MR. HANBURY: Are you aware of any other specific sub-specialisations that the urologists are discussing, or is that level of detail... 12:42
A. I'm afraid you're taking me outside my comfort zone. I'm happy to try to ask -- because there is a group which has the unedifying acronym of PIG, it's the

Planning and Implementation Group, that draws together clinicians and members of the Department, and I can certainly ask whether there are other examples. I think the GIRFT Report was recommending that we would go beyond what was already being put in place by way of the stones, so I imagine that this will be -- there will be others, but I don't have the detail I'm afraid.

67 Q. MR. HANBURY: But you would generally support initiatives from the clinicians, I would hope, following all this? 12:42 12:43

A. Yes. Absolutely.

68 Q. MR. HANBURY: Okay. So moving on to waiting lists. We heard back in about 2018 that Mr. Haynes and Mr. O'Brien put together a sort of document to say -- with the analysis of the theatre capacity essentially they had, they could really only just do red flag and urgent work, and it didn't sort of seem to go any further, sort of escalations and this kind of thing. I mean, was that sort of situation something in retrospect your department should have been aware of at the time? 12:43 12:43

A. So I would have expected that at least the, what was then the Health and Social Care Board, would have been engaged in that conversation, because I know that today SPPG looks at theatre utilisation, theatre availability in respect of services. So I imagine that that was happening in 2018, although I confess to not knowing for sure what the situation was then. 12:43

69 Q. MR. HANBURY: And...

A. So your question was then about the department...

70 Q. MR. HANBURY: I suppose sort of what should have happened then, that looking back if you were in charge then?

A. Yeah. Well I guess perhaps rather than trying to answer a 2018 question, if we identify a capacity challenge today, the question is how best do we address that? And what I'm signalling, given the current financial climate, which isn't the one that I would like us to be operating in, that we have to make the best use of the resources we've got. So we do need to look at how we do things and how we make better use. So, for example, in urology my understanding is that there has been a very significant shift towards day case procedures in all sorts of areas. Now, for me that is a win/win. It's a positive for the patient because the patient will have a better experience, will have a quicker recovery time almost certainly as a result of that, but it's also a positive for the wider system because it's freeing up capacity that otherwise previously would have been used for overnight stays and all of the rest of it. So there's a range of different ways where we need to look at all of those things. I don't think we've got to the end of the list of things that we can do in that respect. 12:44 12:44 12:44 12:45 12:45

If, at the end of that then there's still further capacity, then of course that's the area where the investment is then needed in order to address that. So

that's my thinking process as to how we would go through that.

71 Q. MR. HANBURY: Okay. Thank you. Just one last thing on waiting lists. I saw you had your change and withdrawal policies. So obviously some more critical look at what actually is on the waiting list and looking, I guess, at the sort of lower priority procedures, for example, vasectomy, in the sort of context of people waiting a long time for more urgent things. I mean is that something that clinicians are now looking at, not just for urology but for other specialties where there's a conversation about lower priority treatments and whether the health system can and should fund them? 12:45 12:46

A. We've certainly started to look at that. It is a complex area, because I think it's fair to say at the moment the public expectation remains that if there is a procedure which they have a need for, a clinical need for, then it should be delivered. But there is a reality that for those who are facing priority -- procedures, for example, which are routine in nature, and perhaps then our waiting lists are not moving quickly enough and they're not getting to the top of those lists any time soon. So I do think that that is a conversation that needs to be developed and grown. As I said we are, I think, really in the footholes of that. 12:46 12:46

72 Q. MR. HANBURY: Okay. Thank you. Moving on to national audits. They can be a sort of good driver of quality

and change. Talking to the urologists, there was legal or administrative difficulties submitting Northern Ireland patients to BAUS, the British Association of Urological Surgeons Audit. I mean is that something that's still a problem in your view, or if it is, is that something that you can help us with? 12:47

A. Yeah. So, there have been some challenges in terms of how patient information is shared. It's and information governance challenge. There was some legislation passed in 2016 that needs to be updated in order to enable that. I think at the time that the legislation was passed a number of Assembly members had some concerns about how patient information would be used. But there are, I think, strong arguments as to why being part of national clinical audits would be a good thing for everybody, including for those patients, in terms of giving greater assurance about safety and quality and identifying any areas of concern at an earlier stage, which is part of the fundamental problem that underlines both this Inquiry and the Neurology Inquiry. So it is something that, you know, I don't know whether it's something the Inquiry is going to make a recommendation around, but I can absolutely see the benefits of removing anything that would be an inhibitor in that area. 12:47 12:48 12:48 12:48

73 Q. MR. HANBURY: Thank you. Just the last one from me really. Long outpatient waits and waits for follow-ups and things is a recurrent theme in England as well as Northern Ireland. I was interested -- just one comment

from the Royal College of Surgeons action thing was about 82% of patients don't mind travelling up to an hour, which was I think in your statement. In view of that, do you think looking back the initiative to do lots of outreach clinics is still a good one or has that thinking changed? 12:49

A. I'm not aware of there having been a change in that area. I think where it is sensible to do so, delivering outpatient clinics close to where people live is a good thing. But, you know, obviously one needs to ensure that that's not at an unreasonable cost in terms of what else could be achieved. There is a move more generally to look at where patient initiated follow-up might be a sensible way forward. Obviously that doesn't apply to all areas, but there are plenty of best practice as to where that co-operate. So that too, whilst it's not quite the question you asked, is another area that is being looked at at the moment. 12:49 12:50

MR. HANBURY: Thank you. I think I'll stop there. Thank you, Chair. 12:50

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

74 Q. DR. SWART: Thank you. I think you've helped us to understand how things are at the moment in a very clear way. I'm interested in the whole area of implementing recommendations from inquiries, and this is something that has been looked at recently in England, and I have, myself, been on the end of many, many recommendations over many, many years, and the overall learning seems to be that the recommendations are 12:50

accepted, but they're not always implemented, and that I'm sure won't surprise you. So that's one feature. The other feature is that in nearly all the inquiries the themes are similar. They're not exactly the same, but there's a definite congruence around things like culture, commitment to learn, promise to act, safety and all of those things. So you've put together this group, which hopefully will try and bring sense to the recommendations from a number of inquiries and a number still to come. 12:51

What discussions have you had in that group of trying to put some proportionality into that? Because you've got already a lot of recommendations. It's a very broad range of things. Not all of it will be achievable. Not all of it is resource dependent, but quite a bit may well be. What discussions has the group had about how to pull the building blocks out? Now you've mentioned a few things that you're concentrating things on straight away in advance of regulation, and I can see that. But have you had other discussions about "these things are the most important" and what those things might be in your head, what's the sense? 12:51

A. Well, part of the reason for trying to join together the implementation groups on the different inquiries was to enable that wider view to be taken and to understand where there are inter-relationships, because not every inquiry recommendation necessarily points you 12:52

in precisely the same direction. So, you know, I'm clear that we're trying to take the spirit of the recommendation, you know, and that includes, you know, obviously the Neurology Inquiry is more recent, but being able to talk to those who were on the Panel for 12:52
that Inquiry to understand precisely what they meant, because sometimes the words don't translate as well or it's harder sometimes to be sure that we've got that exactly right. And then from that to try and take an approach that by having the themes that are set out, 12:53
themes set out in the statement that they offered, that's a way of trying to join this up with normal work, because we shouldn't see -- you're doing an Inquiry over here and you've got this over there. So, you know, if the issue is around workforce, how does 12:53
this get embedded in the workforce strategy so it becomes a part of business as usual as soon as possible, whilst still needing to be able to report on the implementation of that recommendation to satisfy proper accountability mechanisms elsewhere. 12:53

For me, you know, this is all about culture really.

75 Q. DR. SWART: Yes.

A. And it is about the supporting -- all of these mechanisms are mechanisms to support the delivery of 12:53
the culture you're trying to achieve. I think I'm clear that there is a will within the system to take action, because no Trust, no clinician or senior manager wants to be subject to an Inquiry in the

future. And so I think that there has been quite a positive response, a willingness to learn and take on board what is intended here. And for me that's a positive sign, and one that means that, you know, we're certainly not -- we've not got there yet, but we are making good progress in a number of areas, and that whole focus for me around the Just, Open and Learning Culture, the idea that that could become a patient safety framework essentially, an English patient safety framework that we could draw on that we've been looking at. So for me that would be one of the critical things that might emerge from this series of inquiries and might then act as a strong pillar for the future, if that - does that answer your question? 12:54 12:54

76 Q. DR. SWART: That's exactly what I was asking about. So my own experience is that patient safety is the one thing that everybody can easily align around. However, it's a glib word, and people have to understand what it means, and I don't just mean managers and people who aren't clinicians, the clinicians themselves need to have a common understanding of what that is, and that requires training, it requires attention, the same kind of attention up and down the line, if you like. So I think if you look at the inquiries, they recommend various things in that area and it generally doesn't happen in a coordinated way, and that leads me to the question about what, what discussions have you had about the need for a common understanding around values and safety, and the safety culture dimensions across 12:55 12:55

health, social care, and so on in Northern Ireland, because it isn't just about the acute sector, if this is to work well it has to involve primary care and social care and so on. Has that been built into discussions at any point? That's really stealing from the English Patient Safety Framework documents that are out there. But where has that gone? Is there thinking in that space?

A. So I think the Patient Safety Framework that I've seen from England has around 10 different segments to it. 12:56

77 Q. DR. SWART: Yes.

A. And what we've done is we've begun working on a number of those segments, but we haven't yet taken it forward in all of the areas. So there will already be excellent guidance in relation to safety in a range of areas, but I'm not conscious that we have necessarily drawn that altogether in one place yet.

78 Q. DR. SWART: Yes. Well I think it's the area that people have struggled with, despite recommendations in England where there has been a lot of work in this area, it's still not really embedded, for a variety of reasons. And that brings me to the Board as well. You, obviously, correctly have stated the responsibility of the Health and Social Care Trust itself, and of their Board, and of the importance of the Board. But training for Boards in this area has not, I don't think, necessarily been undertaken in a systematic way. Is that something which could receive some sort of Department support, rather than each Trust

being asked to invent their own programmes, modelling again on things that have happened in England?

A. Certainly. Look, I mean I agree that we should haven't five different versions of something like that. I'm open to discussion. The Trusts have been -- I've been very keen to try and encourage a system wide approach and to try to -- in all sorts of areas, not just in relation to patient safety. 12:57

79 Q. DR. SWART: Yes. Yes. Yes, I'm just using that as a pin. 12:57

A. And to be fair, the Trust Chief Executives have been keen to take that up. So they are looking at the development of what they're calling a provider collaborative, that might be a way to try to work out which bits need to be done on a common basis, as it were. 12:58

80 Q. DR. SWART: Yes.

A. Now whether it's the Department or that patient collaborative that were to lead something like the development of training in this area, I'm happy to consider further. But your point that, you know, we should have something that enables Board members to understand their roles in this area is a valid one and, you know, if we need to do more in that area I'd be happy to look at that. 12:58 12:58

81 Q. DR. SWART: This again comes from learning in England where the comments made in various bits of documentation that the Non-Executive Directors are not actually able to challenge around quality and safety

issues and so on, because they haven't had appropriate training and haven't been expected to do so. Now that may not be universal, but it is also my own experience that its variable.

A. Yes. 12:58

82 Q. DR. SWART: Mostly these people are very receptive to understanding more about it, it's not too difficult, too time consuming, nor too expensive, frankly?

A. And I think we just need to be clear on what we're training them on. 12:59

83 Q. DR. SWART: Exactly.

A. We're not asking them to become clinical experts.

84 Q. DR. SWART: No.

A. And they need to work out what assurance they can take from those who are tasked with providing those 12:59 assurances.

85 Q. DR. SWART: Yes. No, that's why it has to be targeted in a certain way.

A. Yes.

86 Q. DR. SWART: On a similar vein, but not the same, we 12:59 have heard quite a lot about difficulties in the medical leadership hierarchy at Southern Health Care Trust in terms of dealing with certain issues, and that might be dealing with concerns about doctors leading up to MHPS, it might be an operational professional 12:59 confusion, a lot of it is around the time for medical leadership, the development of medical leadership. If clinical leaders are going to be in positions of "authority", just to use that word, it does need

development and training. What is your view on whether Trusts should do that all individually or whether that should be a department leadership centre endeavour and how comprehensive that needs to be?

A. So, the leadership centre already offer a range of leadership courses that are open on a multi-disciplinary basis, and I was at an event a couple of months ago hearing some of the conclusions from the work, and there were doctors, and nurses, and AHPs, as well as managers, and I think in that kind of leadership training the multi-disciplinary approach had a lot to commend itself, and I was -- the energy in the room was really good to feel as well. 13:00 13:00

There may, in addition, be some clinical leadership that is required, and one of the things that I am keen to try to inculcate is a sense that, you know, the problems that we face as a system are problems that we need all parts of our system to come together to try to resolve, and I've been talking to our Chief Medical Officer and Chief Nursing Officer about how we might go about perhaps, you know, starting with some sort of a conference or something like that that will enable that to happen. And from that, I think rather than -- I'm always a bit reluctant, not being a health expert, to sit at the centre and say "What we need is one of those over there somewhere", much better if that emerges from within the group, drawing, as you say, on best practice as to what might be needed. So, you know, I think 13:00 13:01 13:01

absolutely I'm sure that there's something that we need to look at in that space.

87 Q. DR. SWART: Okay. Finally just the Encompass Epic thing sounds amazing, if that can all work.

A. Yes. 13:02

88 Q. DR. SWART: What are the risks identified so far in terms of this programme and what are the mitigations against that that have been built-in?

A. Well at a granular level there is a very extensive risk register, and set of mitigations, as you might expect. 13:02

89 Q. DR. SWART: Yes. Yes.

A. And, you know, the risk is that, you know, there have been Epic implementations that haven't worked, but the vast majority do work, and all the more recent ones have worked. I have to say given the experience in the 13:02 South Eastern Trust, that's given me confidence about the ability for the future. We do have some challenges. There was a downturn in terms of the level of both outpatient and in-patient and day case procedures in the immediate period of implementation, 13:02 and that is normal, but we've found it more difficult to get back to the level that we need to be at. So that is a core focus at the moment, because clearly Belfast is a much bigger Trust and as a result the impact would be still greater if we weren't able to 13:03 achieve that more quickly.

But part of my confidence lies in the fact that the South Eastern Trust have acted as the pathfinders and

that, therefore, many of the problems will have been resolved before other Trusts get there. Belfast have some regional services, so for them they'll be doing some things for the first time, so that's an area of particular focus. But beyond that, you know, it is about enabling the capacity to change within the workforce because, as I said, it affects everybody and requires everybody who interacts with a patient to do things differently, and that is a big change if you've spent many years doing things in a particular way. So it's not just about attitudes to change, it's also building capacity and so on. 13:03 13:03

So there is -- there was a really strong systemwide effort at the time the South Eastern Trust went live, both in terms of surging people into the South Eastern Trust, but also an acceptance that there would be a need for other Trusts to help out in terms of some urgent procedures, and that's still ongoing at the moment. So those are the kinds of mitigations that exist. So I don't know if I've answered your question? I can give you a much more... 13:04 13:04

90 Q. DR. SWART: I mean it's not really answerable in that way.

A. Okay. 13:04

91 Q. DR. SWART: I was really just wanting a sense of, you know, did you have enough clinical involvement in it, enough ongoing support?

A. Yes.

92 Q. DR. SWART: You know what -- how is this being sold in terms of safety? I mean, you know, these things have a major impact, don't they?

A. Yes. I mean I think everybody sees that it has a massive patient safety impact, for the kinds of reasons I described earlier. There is strong clinical buy-in and, you know, that's been really important as part of this. So this isn't something that someone in an IT Department thinks is a good idea. This is a major change driven by technology, but it's the major change that we're focused on, the technologies to enable us to get there. 13:04 13:05

93 Q. DR. SWART: And just -- I started off with learning from inquiries. We will obviously be producing a report. You will have looked at lots of inquiry reports, you've got this group set up, what is most useful in terms of how these things are phrased? So, you know, just to start you off, it's probably not useful to have 300 recommendations that are very specific, if I was on the receiving end of it. But what is most useful? Is it more useful to do what Bill Kirkup did in East Kent, which is to say "Look here guys, I've written lots of inquiries and nobody implements them and it's all too complicated, so I'm going to phrase these recommendations differently", and really what he's doing is getting to the spirit, to use your words, what is most useful? 13:05 13:05 13:05

A. So for me, as I think I said in my earlier evidence, I'm conscious that you are coming to this after other

inquiries have reached recommendations. So I suppose my -- what would be most useful to me is if, in looking at what you recommend, you try to build on what is already there and, as I said, put wind in the sails of what you think is going in the right direction and be 13:06
clear about what different or additional is needed in order to address the challenges. You've heard lots of evidence. Because time has passed quite significantly, the world has also moved on. So part of the -- so for me this is -- I would encourage you to take a system 13:06
view of this. What is it that's needed systemically in order to address things? There may be some specifics, of course, but as you've helpfully hinted, vast numbers of recommendations can be, you know, if you start chasing ticks in boxes rather than a focus on what 13:07
really matters. So it might be just because of the positioning of this Inquiry in the context of other inquiries, it just takes a slightly different approach in order to land it, and then again, if the Panel were, or representatives of the Panel were willing to be 13:07
engaged with afterwards to make sure we had understood properly, that would be extremely helpful as well.

DR. SWART: Yes. Thank you. That's all from me.

94 Q. CHAIR: Thank you, Dr. Swart. Well if it's any reassurance, I'm a great believer in less is more, 13:07
Mr. May, so I don't think you'll be getting 300 recommendations from this Inquiry.

Just a couple of things just when you were giving

evidence that I wanted to ask you about. One of the things that we heard that went wrong here was the fact that because of financial constraints money was diverted from governance systems essentially to frontline services, and as a result people weren't picking up on things. I talked to Dr. O'Kane about this when she gave evidence, how could we ensure that the auditing of systems and the governance systems are sustainable and that that does not happen again? And one of the things she suggested was ringfencing for governance in the financial package that a Trust is given. And I wondered, given that you don't like ringfencing and being dictatorial, but is that one area where there maybe a call for ringfencing that type of finance? 13:08

A. I think I'm just very sceptical about ringfencing and the impact that ringfencing actually has on the way organisations work, and whether it really delivers, because you're only really measuring an input. You're not measuring what is delivered with the money. So, you know I'm conscious -- if you look back, the Trust each year reports on how much it spends on governance activity, which would include all of that accountability piece. For the Southern Trust that has increased from 20 million to 30 million over recent years. So even allowing for inflation, a more than inflation increase, and when SPPG makes an investment for a new service or a new development, there's a 10% add-on designed for additional governance requirements 13:08 13:09 13:09

and/or, you know, the sort of basics that are needed to make it work, as it were. So it's not that there is nothing already provided in that space, that is normal. I would, I think, prefer to be clear what, you know -- this is somewhere where the assurance mechanisms fell down. If there wasn't a function performing these then there was no assurance being provided in this area. And, so, I think it's about being clear on what's the minimum standard that is required in terms of the outcome? Rather than looking at the minimum input required in terms of bums on seats. 13:10 13:10

95 Q. CHAIR: So it's basically directing the Trust not in terms of finance and how they deliver, but what has to be delivered?

A. Yes. 13:10

96 Q. CHAIR: Okay. And coming back to -- well two more questions from me. You'll be glad to know you'll be getting away soon. But joined up information, Encompass is designed to give joined up information to any clinician faced with a patient and to allow a patient a say in their own health care by giving them information. If I've got it in a nutshell that's what it's really designed to achieve. But in the current situation where a lot of people are now taking the situation that they find themselves in into their own hands and are paying for treatment privately, where is the interface between the private treatment and the Health Service treatment? How does that join up in terms of Encompass and providing a clinician who is 13:10 13:11

maybe to see someone in a private setting who then ends up in the health care system for other treatment? Where is the join up? I mean, for example, we saw a difficulty when there was a waiting list initiative with information being given to the private sector, one of the patients who came to speak to us, that information -- their file wasn't handed over, resulting in complications, and very serious complications for the patient. So where is the interface between the private sector and our health care system? 13:11

A. Yeah. So that's an interesting area and one where I might be able to give a fuller answer, if I was able to write. There is no -- clearly the independent sector won't have the Encompass system, so there's no automatic interconnectivity. Primary care have access to Encompass and so can have a sort of a read access to it. So one of the ways in which any connection might be made is through primary care. But we do have, and this goes to -- I think I made a point earlier about safety in two dimensions, one of which has the individual patient at the heart and one of which has all patients at the heart. So with information systems, Encompass might have the individual patient at the heart, but actually if you look at all of the data that's going to be needed Encompass isn't the answer to that problem, and so we're looking to create, something called a data institute, that would enable different sources of data to come together and for us to make sense of that in a better way. And that would then

inform the likes of the Balance Scorecard that I described in terms of Trust management. But I haven't specifically answered your question about the connection with the independent sector. And I think, I think it did come up in a meeting I was in, but I don't remember the detail of it, so I'd like to be able to write to you, if I may? 13:13

97 Q. CHAIR: That certainly would be useful just to know, because obviously from a patient safety point of view it is important that there is that connection in some way. 13:13

A. Yes.

98 Q. CHAIR: Then just one other thing. We're hearing this week from Mr. O'Brien, and we're very well aware of the waiting lists, and one of the points that he makes is that the emphasis in dealing with waiting lists and tackling them is always on the red flag, the cancer patient, whereas there are a lot of people languishing on waiting lists who are equally meritorious in terms of the treatment that they need, but the emphasis is always on the performance of cancer treatment. Now that's not to say that that's not important, but I just wonder has the Department thought about how can we address those people who aren't seen as red flag but may be urgent, may be routine, but who are actually suffering? 13:13 13:13 13:14

A. Well, I think that's at the heart of the challenge that we face at the moment. There is properly a clinical prioritisation, and that goes to the harm that might

come to the individual or the potential from intervention. And, as I said earlier, there is a reality that those on routine waiting lists are not getting to the top of those lists in anything like the timeframe that is acceptable. So our system needs to 13:14
be able to -- we need a way both of being able to meet the new ongoing demand that is coming in every day, week, month, year, and alongside that we will need some additional investment to address the backlog, because the backlog is causing ongoing challenges in all sorts 13:15
of areas that are then making it more difficult to deliver. So primary care, seeing people who are on waiting lists, coming back to them to say their complaints have got worst, or "Am I closer to the top of the list yet?" Our urgent and emergency care 13:15
departments are seeing people who are on a waiting list who maybe their condition has worsened and are then becoming patients there. If we were able to do those two things together then -- and that's easy to say and difficult to do, and I keep coming back to the 13:15
challenges that we face in the short-term, but our approach here is to try to develop an approach that will grow our capacity and then to recognise we are going to need some additional way of addressing some of the very significant backlog that we have at the 13:15
moment, because no -- investment just in more of what we've got is going to get us to where we need to get to in anything like an acceptable time period.

99 Q. CHAIR: I suppose part of that will be managing

expectations for patients. You know, you're saying that everybody expects if they have an issue that they can be treated straight away.

A. Well, yes, or -- yes, indeed.

100 Q. CHAIR: But equally I think one of the success stories, if you like, in the urology field is Lagan Valley and the day cases that are there. And I just wonder is there an education task here that the Department has in educating the public, "Look, you might have to leave Fermanagh and go to Belfast or vice versa, but it'll mean you'll get seen sooner", and I think there is something to be said for informing the public about how they can -- how you're setting about improving the health care system? 13:16 13:16

A. I absolutely think that there's always more that can be done by way of communication. We have had some recent examples where services have moved. Both -- for example, general surgery is not now -- emergency general surgery is not being delivered at either Daisy Hill or Southwest Acute Hospital, and the numbers of people affected are very small. There is -- there are some people who are concerned, but I actually -- I do believe that most people are accepting of the need to travel further to get a proper service, to make sure that the service they're getting is of the same quality there as they would be getting everywhere else, and we've got more to do to persuade others who have not yet got that far, and there's often a concern that because that service is leaving it means we don't need 13:16 13:17 13:17

the hospital at all, and that's not the reality. It is about working out what each hospital is for, and the blueprint document is designed to help to explain that and to say that, you know, this hospital might become a centre of excellence for these things rather than trying to deliver the full gambit of services. And, yes, that will mean some people will need to travel further and that there will be some inconvenience associated with that. But it is still -- it is actually practically going to be the only way that we can deliver a service. Clinicians don't wish to be part of small services where they don't feel they've got the necessary skill set because they don't get to do procedures often enough, and so on, and we can't assure the safety and quality of those services either. 13:18

CHAIR: Okay. Thank you very much, Mr. May. Your evidence has been very helpful.

A. Thank you.

CHAIR: So I think that's us finished for today and I'll see you all again tomorrow at 10:00 o'clock. Thank you. 13:18

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 10TH APRIL AT 10.00 A.M.

13:18

Clinical and Social Care Governance Review

Final Draft Report

November 2019

Report Compiled by: **Mrs J Champion, Associate HSC Leadership Centre**

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

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Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1.0 Introduction

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

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

2.0 Scope of the Clinical and Social Care Governance Review

2.1 Terms of Reference

The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on patient safety and that help people learn.

The following terms of reference were agreed with the Medical Director of the Southern Health and Social Care Trust (SHSCT):

Objectives

- The Trust is seeking to undertake a comprehensive review of the current governance structure including the formulation of recommendations on what a good structure should look like;
- The Review will consider existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach to the organisation rather than in two reporting lines. It will include a review of both clinical and social care governance;

Specifically the work will include;

- *gaining an understanding of the current governance structure and processes in place;*
- *meeting stakeholders to identify what works well and areas for improvement;*
- *undertaking a benchmarking exercise to identify best practice;*
- *reviewing existing and draft documentation including a new Governance Assurance Strategy.*

The outcome will be a written report outlining key findings from the review and recommendations.

2.2 Limitations to Review

As defined within the terms of reference above, the review of integrated governance arrangements within the Trust excluded financial governance. Given the breadth of

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the terms of reference and the timeframe allocated to complete, the review does not claim to provide an exhaustive or exclusive list of all potential gaps in controls or assurance across the organisation at local level which may have arisen during the period of fieldwork.

3.0 Methodology

For the purposes of the Governance Review a standard methodology was adopted which entailed the examination and analysis of documentary evidence and meetings with key stakeholders.

Key to the consideration and analysis of documentary evidence was the evaluation and benchmarking of the Trust's core governance systems and processes of internal control, which underpin a good governance structure, against extant national/regional and best practice guidance and policy. An evaluation of existing accountability/reporting lines was also considered in the review of documentary evidence and during stakeholder meetings and recommendations to improve the Trust's overarching governance structure and internal processes are outlined throughout Section 4 (Analysis and Findings).

3.1 Analysis of Documentary Evidence

A detailed examination and analysis of a large number of policy and supplementary evidence was undertaken as part of the fieldwork for this Review.

Regional Documents:

- The Inquiry into Hyponatraemia-related Deaths, Volume 3, January 2018;
- Procedure for the Reporting and Follow up of Serious Adverse Incidents, HSCB, November 2016.

Core SHSCT Documents/Evidence:

- Annual Report and Accounts 2017/18;
- Board Assurance Framework, May 2018 and June 2019;
- Clinical Audit Strategy, June 2018;
- Clinical Audit Workplan, June 2018;
- Clinical and Social Care Governance Assurance Strategy, March 2019 (Draft only);
- Clinical and Social Care Governance; Children and Young Peoples Service Directorate;
- Clinical and Social Care Governance Indicator Suite, March 2019 (Draft only);
- Controls Assurance Self-Assessments, February 2019 (Emergency Planning, Governance, Risk Management and Health & Safety);
- Corporate Plan 2017/18 and 2020/21;
- Corporate Risk Register, December 2018;
- Directorate Governance Meetings Sample Agendas;
- Directorate Risk Registers;
- Governance Committee Agendas and Minutes (May & December 2018);
- Governance Arrangements for Social Work & Social Care, SHSCT, February 2019;

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- Health & Safety Policy, December 2014;
- Health & Safety Risk Assessment, Version 3, H & S Department, November 2019;
- Incident Management Procedure, October 2014:
- Integrated Governance Framework, September 2017;
- Internal Audit Report, Management of Standards and Guidelines, 2018/19;
- Internal Audit Report, Morbidity & Mortality 2018/19;
- Medical Leadership Review, June 2019;
- Patient Safety Programme SOP, January 2019;
- Policy for the Management of Litigation Claims, November 2018;
- Procedure for the Management of Complaints, November 2018;
- Risk Management Strategy, 2014;
- Risk Management Strategy 2019-2022 (Draft only);
- RQIA Review of Serious Adverse Incidents Process in NI Questionnaire (Draft only);
- Senior Management Team Minutes (Sample from March 2019);
- Social Workers & Social Care Workers: Accountability and Assurance Framework February 2019;
- Standards and Guidelines Monitoring Process – Change Leads;
- Terms of Reference;
    - Audit Committee, February 2018;
    - Governance Committee, February 2018;
    - Health & Safety Committee,
    - Lessons Learned Forum;
    - Quality Improvement Steering Group;
    - Senior Management Team;
- Trust Board Minutes September 2018 - January 2019;
- 'Your Right to Raise a Concern (Whistleblowing) Policy.

3.2 Meetings with internal stakeholders

The following key stakeholders were interviewed as part of this review:

- Chairman of Trust Board;
- Nominated Non-Executive Directors;[1]
- Chief Executive, Executive Directors and Directors and members of the Senior Management Team;
- Director of Pharmacy;
- Interim Assistant Director Clinical and Social Care Governance and key related staff including the Clinical Audit Management and Governance Coordinator;
- Board Assurance Manager;

[1] The Chairman of Trust Board nominated three Non-Executive Directors to participate in the Review. The nominated Non-Executive Directors included the Chair of the Governance Committee.

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- Directorate Clinical and Social Care Co-Ordinators;
- Patient Safety & Quality Manger (Standards & Guidelines), Acute Services
- Project Manager, Medical Directorate.

4.0 Findings and Analysis

4.1 Governance Structures

4.1.1 Trust Board

The purpose of a Trust Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and social care is in safe hands. Effective Boards demonstrate leadership by undertaking three key roles; formulating strategy, ensuring accountability by holding the organisation to account for the delivery of strategy by being accountable for ensuring the organisation operatives effectively and with openness and by seeking assurance that systems of control are robust and reliable.[2] The role of the SHSC Trust's Board is defined in a number of key documents which are outlined below.

The Trust has an extant approved Standing Orders, Standing Financial Instructions and Scheme of Delegation which in line with best practice is available to staff and the public via the Trust's website.

As defined in the Trust's Standing Orders (SOs), the Trust Board is required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance activities. From 2006, HSC organisations have been encouraged to move away from silo governance and take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and organisational objectives.[3]

The Trust Board is responsible for ensuring that the objectives of the organisation are realised. The Trust has communicated its strategic purpose and corporate objectives in its Corporate Plan 2017/18 to 2020/21.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance.[4]

[2] NHS Leadership Academy '*The Healthy NHS Board: Principles for Good Governance'*. 2013.
[3] Department of Health '*Integrated Governance Handbook'* February 2006.
[4] SHSCT '*Draft Integrated Governance Framework'*, September 2017, Section 4.

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4.1.2 Trust Board Meetings

In line with recommendations from the Francis Report,[5] and best practice, the agenda for Public Trust Board meetings includes an account of a service improvement or learning from a service user experience. Post-Francis, HSC Trust Boards were encouraged to put quality, safety and learning for improvement at the heart of the Board agenda. Learning from service user experience defines the Trust Board agenda, reminding Members of the organisation's vison and values and acts as a catalyst to continue to strive to improve the quality and safety of care provided.

The Board Assurance Framework, outlining the organisation's principal risks is required to be reviewed by Trust Board and tabled for discussion at public meetings on a six monthly basis (see Section 4.4 below). This is evidence that the organisation is committed to being open and transparent. It was noted that the Trust has a busy Board agenda and this may not allow for full discussion by the Board of Directors. It was noted however, that the Corporate Risk Register, is also reviewed at the Governance Committees of Trust Board and Senior Management Team meetings (see also Sections 4.2.2 and 4.9.2). Stakeholders indicated that the linkages between the Board Assurance Framework and the Corporate Risk Register could be strengthened (see Sections 4.4 and 4.8).

The Trust holds monthly Board Meetings (with the exception of July) which are held alternatively in public session and workshop format. Confidential sessions, when required are held immediately prior to the Board meeting. Senior stakeholders advised that Trust Board and Board Committee agendas are very busy and throughout the year there are a significant number of Board reports, covering a wide range of complex issues, which are presented for approval or assurance.

Trust Board workshops allow for detailed discussion on a range of strategic matters including detailed reports for example the Statutory Functions Report and service developments. The Workshops are essential for providing the Board of Directors the time and background information they require to make strategic decisions and fulfil their scrutiny and challenge function. This will be a particularly important in implementing the IHRD recommendations on the Board's Statutory Duty of Quality/Board Effectiveness which have highlighted the need for time for Board effectiveness, development and for understanding patient safety objectives.[6]

The Reviewer has noted that Internal Audit have provided the Trust with a 'Satisfactory Assurance' level for Board Effectiveness. Senior stakeholders advised that they would wish the Internal Audit Board Effectiveness Action Plan to be formally reported and reviewed by a Board Committee for assurance.

There is a time allocation for Trust Board Agenda items. It was noted from the minutes of those Trust Board meetings held in public session, that Patient and Client Safety and Quality of Care Reports are included in a standing agenda which also

[5] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* February 2013. HC 947 London. The Stationery Office.

[6] IHRD Recommendation 55 ~ '*Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objective'*.

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includes Strategic and Operational Performance Reports thus demonstrating a balanced agenda. There is evidence of Non-Executive Director challenge in the area of patient and client safety and quality for example in relation to infection prevention and control training performance and complaints response performance targets. Given the proposal to constitute a Performance Management Trust Board Committee ***it is recommended that the Trust Board review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda.***

The Reviewer can confirm that Trust Board agendas and minutes are readily available on the Trust's website from April 2009 to date.[7]

4.1.3 Trust Board Committees

The Trust Board exercises strategic control over the organisation through a system of good governance which includes Trust Board Committees:

- Audit Committee;
- Endowments and Gifts Committee;
- Remuneration Committee;
- Governance Committee;
- Patient and Client Experience Committee.

It is recognised that Accounting Officers and Boards have many issues competing for their attention. One of the challenges they and their members face is knowing whether they are giving their attention to the right issues. Key to addressing this is 'assurance', defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework".[8]

Assurance draws attention to the aspects of risk management, governance and control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. An effective risk management framework and a risk-based approach to assurance helps an Accounting Officer and Board to judge whether or not its agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources.

At the heart of a good governance structure is the constitution of Trust Board Committees and Sub-Committees. The Trust Board Committees, and in particular the Audit and Governance Committees, can help the Accounting Officer and Board to formulate their assurance needs, and then consider how well assurance received actually meets these needs by gauging the extent to which assurance on the management of risk is comprehensive and reliable. Assurance cannot be absolute so the Committees (and Trust Board sub-committees) will need to know that the organisation is making effective use of the finite assurance mechanisms at its

[7] IHRD Recommendation 70 ~ *'Effective measures should be taken to ensure that minutes of board and committee meetings are preserved'*. The Department of Health IHRD ALB Board Effectiveness Workstream are reviewing this recommendation and are also considering the ease of access to board and committee information.

[8] Department of Finance '*Audit & Risk Assurance Committee Handbook NI*' April 2018.

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disposal, targeting these at areas of greatest risk. The Board Assurance Framework and Corporate Risk Registers and their functions in supporting a risk-based approach are considered in Section 4.9.

4.1.4 Audit Committee

The Audit Committee is the Trust's statutory committee which deals with all aspects of financial governance.[9] The Audit Committee has no executive powers, other than those specifically delegated within the Terms of Reference. The Audit Committee is a non- executive committee of Trust Board and the Director of Finance and representatives from Internal and External Audit will normally attend the meetings. In line with best practice, the Chief Executive is invited to attend at least twice annually to discuss the process for assurance that supports the annual Governance Statement. In addition, other directors are required to attend when the Audit Committee is discussing areas of risk that fall within their area of responsibility or accountability.

It was noted from stakeholder meetings that the non-financial risk-based Internal Audit Reports (e.g. Management of Standards and Guidelines) would be tabled at the Governance Committee (see below) for more detailed discussion. The Trust should consider revising the terms of reference for the Audit Committee to enable the Interim Assistant Director for Clinical and Social Care Governance to be in attendance to facilitate the triangulation of integrated governance information.

The Trust has an Internal Audit Forum chaired by the Executive Director of Finance and Procurement. The Internal Audit Forum has successfully significantly increased the number of Internal Audit Plan recommendations that have been follow-up by Management (90% actions were reported as 'undertaken' at the time of Review).

4.1.5 Governance Committee

The Governance Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee is appointed by the Trust Board from amongst the non-executive directors following recommendation by the Trust Chair and is required to consist of no less than three members. The Trust Board Chair confirmed that she attends Governance Committee meetings when there is a particular item on the agenda that she wants to review in more detail. The following are currently invited to attend; the Chief Executive, Executive Directors (with the exception of the Director of Finance and Estates), members of the Senior Management Team and the Director of Pharmacy. The [Interim] Assistant Director of Clinical and Social Care Governance also attend the committee and provide papers. ***It is recommended that the Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director***.

[9] Financial governance is not included within the terms of reference for this Review, however, an understanding of the role of the Audit Committee was required to gain an insight into the overall management of integrated governance within the Trust.

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The remit of the Committee is to ensure that there are effective and regularly reviewed structures in place to support the effective implementation and continue development of integrated governance and that timely reports are made to Trust Board. The Committee is also responsible for a number of assurance functions including; assessment of assurance systems for effective risk management, ensuring there is sufficient independent and objective assurance as to the robustness of key processes and for ensuring that principal risks and significant gaps in controls and assurance are considered by the Committee and escalated to Trust Board as required. The Chair of the Governance Committee provides an annual report on the undertakings of the Committee to Trust Board which is an example of best practice.

The Agenda for Governance Committee is approved by the Senior Management Team. ***It is recommended that the Chair of the Governance Committee is fully involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020***.[10]

The annual Governance Statement is brought to Governance Committee for review and approval. The Statement indicates that the Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services (see Integrated Governance Section 4.4).

The Corporate Risk Register is presented to Governance Committee on a quarterly basis. From senior stakeholder meetings and review of minutes it is planned to review a small number of corporate risks on a rolling basis to enable a more detailed discussion and afford the Non-Executive Directors the opportunity for scrutiny and challenge is a secure environment (see also Risk Registers Section 4.9).

Regular reports on integrated governance functions are reviewed at Committee including Adverse Incidents, Morbidity and Mortality, Management of Serious Adverse Incidents (SAIs), Claims, Whistleblowing Cases. The Medical Director and Interim Assistant Director Clinical and Social Care Governance are reviewing the format and content of reports to provide high quality intelligence and not just hard data. The Interim Assistant Director has also developed a draft suite of key performance indicators for clinical and social care governance which will help 'triangulate' data with different information sources and should form a key component of future governance reports to Committee. It is recognised that the collation and analysis of this data is labour intensive and resource dependant and currently there is insufficient managerial and administrative support and ITC infrastructure to support this governance function (see also Sections 4.22 and 4.23). ***It is recommended that the clinical and social care key performance indicators are further developed and submitted for approval through the Senior Management Team.***

The Governance Committee also receives a report on Freedom of Information (FOI), Environmental Regulation and Subject Access Requests (SARs). The Report

[10] Senior stakeholders suggested that a three year plan should be developed.

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contains information on performance against timescales for processing requests and information on the nature of the requests which is good practice and there is evidence within the minutes of discussion stimulated by Non-Executive Directors. [11]

The Chief Executive advised that the Trust are to constitute a Performance Management Trust Board Committee (see below). The Governance Committee should therefore review its Terms of Reference. There is a need to focus on the detail of the Board Assurance Framework as well as the Corporate Risk Register on at least an annual basis at either a Trust Board workshop or at Governance Committee.

In line with best practice, the Chairs of the Audit and Governance Committee should meet annually to ensure an integrated approach to governance within the Trust and no overlap with agenda items.

4.1.6 Patient and Client Experience Committee

The Patient and Client Experience Committee was established as a subcommittee of the Trust Board. It has no executive powers, other than those specifically delegated in the Terms of Reference. The role of the Committee is to provide assurance that the Trust's services, systems and processes provide effective measures of patient, client and carer experience and involvement and to identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience and to ensure that patient, client and carer experience improvement initiatives are in place to address identified shortcomings and that these are monitored.

The Chief Executive advised that the terms of reference were being considered in the short term, with a view to refocus the role and responsibility of this Committee.

4.1.7 Performance Management

It has been agreed that a new subcommittee of Trust Board will be constituted during 2019/20 to ensure a strategic focus on performance management.

4.1.8 Senior Management Team/Governance Management Board

The Trust has a Senior Management Team (SMT) that is accountable to the Chief Executive. The Terms of Reference stipulate that the SMT is responsible for the leadership, strategy and priorities of the Trust and to oversee all aspects of Operational activities to ensure that the Trust meets its Statutory Requirement and provides high quality and effective services.

The Terms of Reference provided to the Reviewer are not dated. The Terms of Reference stipulate that all members of the SMT are individually and collectively responsible for the leadership of the following; Strategy and Planning, Delivery and Performance, Communication and Engagement, Governance and Risk Management The Terms of Reference define a model agenda of standing items in Section 8

[11] This will assist the Trust by forming a basis for implementing IHRD Recommendation 72 ~ *'All Trust publications, media statements and press releases should comply with the requirements for candour and be monitored for accuracy by a nominated non-executive Director'.*

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'Cycle of Business' do not include quality and safety with the exception of Infection Controls within Performance and Delivery. A review of sample agendas confirm that quality and safety is discussed.

The Terms of Reference stipulate that papers, reports and presentations for submission to the Board of Directors will be considered by the SMT at the meeting one week prior to the Board meeting which is standard practice. In respect of Trust Board papers, SOs stipulate that the 'Agenda will be sent to members at least 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency'.

For SMT meetings the Terms of Reference stipulate that the collation of the agenda, issuing papers/reports are required at least 24 hours in advance of the meeting. Senior stakeholders advised that on occasion there may be a requirement to table an agenda item for urgent consideration and approval after the deadline. The Reviewer recognises that this should be avoided wherever possible to ensure that SMT members have time to review the information, this should be balanced with potential loss of opportunity and the Terms of Reference should allow for an urgent provision. (See also Weekly Governance Meeting/Debrief Section 4.23.2).

It is recommended that the SMT Terms of Reference are reviewed, including providing a provision for tabling urgent papers for consideration after the deadline [in exceptional circumstances].

The Terms of Reference also stipulate that once a month the SMT will meet as a Governance Management Board with the staff from the Governance Department in attendance. Section 2 of the SMT Terms of Reference constitute the terms of reference for the Governance Board. Roles and responsibilities include; ensuring the governance framework is fully implemented, monitoring and reviewing the Trust Risk Register and identifying Corporate Risks, reviewing and updating the Board Assurance Framework, escalating risk management issues to Trust Board and approving and reviewing policies that need to go to Trust Board for approval. The SMT Governance Board is also required to monitor patient safety and ensure continuous improvement and receive and approve reports/action plans for presentation to the Governance Committee. ***It is recommended that the remit and responsibilities of the SMT Governance Board are reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board see Sub Committee Structure proposals at Section 4.1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Framework/Strategy.***

4.1.9 Good Governance Structure: Trust Board Sub Committees

The Integrated Governance Framework contains an organogram depicting the organisation's high level governance structure including Trust Board, Board

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Committees, SMT and Directorate and Professional forum. [12] The Reviewer is unable to provide a definitive list of all subcommittee and advisory groups from the written evidence considered. However, from the evidence provided by stakeholders and the review of a range of policies and procedures a number of other integrated Governance Trust Committees, Steering Groups and Advisory Groups have been constituted e.g. Quality Improvement, Health and Safety, Outcomes Review and a Directors' Oversight Group for the implementation of the IHRD Recommendations (see also the Trust's Integrated Governance Framework Section 4.4 below).

Senior stakeholders advised that current arrangements appeared to lack connectivity. From the evidence it is difficult to clearly define the accountability linkages and reporting arrangements between and from the various sub groups and advisory committees to Trust Board via the Senior Management Team. Stakeholders identified a number of accountability/reporting lines including; operational and corporate directorates, professional and expert committee. Clear lines of accountability are crucial to provide the Board of Directors with the assurance that there are robust and transparent governance arrangements in place. Additionally, it is important that staff and stakeholders have clarity on the lines of accountability within the organisation's assurance framework model.

Key to a good governance framework (structure) is the establishment of a robust assurance and accountability framework underpinned by sound systems of internal control the structure which supports the Trust Board and its Committees. ***It is therefore recommended that the Trust's existing Governance Structures are reviewed as a matter of urgency and Trust Board Sub Committee/Steering Groups are constituted to which integrated governance steering groups and committees will report and provide the organisation with a robust assurance framework (see below and Appendix 2) and a single line of assurance reporting to Trust Board through SMT.***

A Quality Improvement Steering Group has recently been constituted which pulls together some of the integrated management functions. The remit of that Steering Group is defined in the draft Terms of Reference provided as being responsible for ensuring that the Quality Improvement Framework is developed and delivered by the SMT and Trust Board.

It is recommended that the constitution of Executive Directors/Directors oversight/ steering groups should be considered with the following remits:

- Clinical and Social Care Governance – Quality Improvement and Safety;
- Corporate Governance;
- Patient and Client Experience and Engagement.

This will effectively group many of the existing sub committees and specialist advisory groups that exist within the organisation and provide a single accountability/ reporting line through the Governance Board of SMT to the respective Trust Board

[12] Integrated Governance Framework 2017, Figure 2.

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Committees. In considering this sub-committee structure the Trust should ensure that there is no duplication of functionality of groups, forums or advisory committees. The Steering Groups should review the terms of reference of the sub groups and advisory groups on an annual basis and should also provide oversight of progress of any action plans or work plans. (The list of functional areas, advisory and expert groups potentially providing reports to the Steering Groups in Appendix 2 are examples only and do not indicate the need to constitute additional sub groups). ***Terms of Reference and annual work plans/action plans, where applicable should be held centrally (See Role of Board Secretary Section 4.2)***.

In response to all stakeholders who believed that there was a gap in the current framework regarding shared learning the Chief Executive advised that the proposed Steering Groups should be required to report on learning within their Terms of Reference and this would be a vehicle to bring together all aspects of learning from across the integrated governance arrangements including user experience. Senior stakeholders also advised that the role and function of the Lessons Learned Forum should be reviewed as a matter of urgency (see Section 4.20).

It is also recommended that any short term Director's Oversight Groups are added to the Governance Structure for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group. This will provide staff and other stakeholders with clarity about the governance assurance and accountability arrangements.

It is recognised that the development and maintenance of an improved governance structure and assurance framework will require the oversight/ input of someone with expertise in Board Governance and Assurance. Additional resources (administrative and ITC support) will also be required to implement this recommendations (see also Section 4.2 Role of Board Secretary, and Section 4.23 Clinical and Social Care Governance Structures).

4.1.10 Committee Terms of Reference

A range of terms of reference (ToR) were analysed during the Review. The Audit and Governance Committees use a common template which meet good practice standards. Minutes of Board meetings reflect that their terms of reference are reviewed annually. ***To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups***.

The terms of reference as a minimum should include the following:

- Constitution;
- Membership (Including chair, deputies and administrative support);
- Remit or high level purpose;
- Frequency of meetings;
- Authority/Delegated Powers;
- Quorum;

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- Duties and responsibilities;
- Reporting arrangements;
- Revision dates.

All terms of reference should be reviewed annually and submitted to the relevant overarching Committee for approval. Approved terms of reference should be submitted to the Corporate Clinical and Social Care Governance Department and held in a shared folder. It is recognised that this will be an additional function for the Corporate Clinical and Social Care Department whose resources are already stretched (See Section 4.23). This function could be overseen by the creation of a Board Secretary as described below.

4.2. Role of Board Secretary/Head of Office

The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Assurance Framework (incorporating the integrated governance strategy Sections 4.1.9 and 4.4).[13] This individual would be required to have a high level understanding of board assurance and board governance and would have the responsibility for ensuring that all Trust Board committees and sub committees are fully serviced and functioning and that their terms of reference are annually reviewed. They should be fully informed of the activity of committees and assist in making decisions on which issues can be resolved at subcommittee level and which issues may represent a high level risk to the organisation and may need to be escalated to the Board for debate and decision.

The Board Secretary/Head of Office should work closely with the Chief Executive, the Chairman of Trust Board and the Non-Executive Directors. They should be a high level appointment with the skills to act at Board level and be an expert in discharging their functions. They should be conversant with the Trust's Standing Orders/Standing Financial Instructions and the Scheme of Delegation. The post holder would hold line management responsibility for the Administrative Team in Trust Headquarters.

4.3 Professional Executive Directors – roles and responsibilities

The Northern Ireland Audit Office (NIAO) Guidance[14] acknowledges that role ambiguity can effect the function and effectiveness of the Board of Directors. As described above, concerns were expressed about the multiple reporting lines to Trust Board. Staff and other stakeholders should be clear on the roles and responsibilities of Executive Directors. The description of Executive Director functions are, by nature, generic in SO/SFIs therefore it is important that the full range of their accountability and responsibility are adequately outlined in the Trust's strategy and policy documents e.g. the Integrated Governance Framework and Risk Management Strategy. The Chief Executive indicated that the Job Descriptions for the recently appointed Executive Directors (Medical Director and Interim Executive

[13] The role of Company Secretary is described in the DoH (2006) *op. cit* pages 68 and 69 . The evidence for the efficacy of the role were based on discussions that took place with FTSE 100 companies.
[14] NIAO 'Board Effectiveness ~ Best Practice Guidance', November 2106.

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Director of Nursing) were strengthened in respect of their integrated governance functions.

The role of the Executive Director Social Work is detailed in a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust, which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019 (Section 4.5). The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework for social work and social care. Clarity of role function is particularly important where an executive director has a dual role and has also operational management accountability and responsibility.

The Medical Director is the Executive Director with responsibility for providing assurance to Trust Board that effecive systems and processes for good governance, including those arrangements to support good medical practice. The strategic role of the Executive Medical Director in respect of risk management and clinical and social care governance is considered in more detail below.

The [Interim] Executive Director of Nursing is the lead Director for Nursing and Allied Health Professionals Governance and has responsibility for the strategic leadership for patient and client experience. The Exectuive Director of Nursing provides an annual Professional Nursing and AHP report to Trust Board and also provides a report on Quality Indicators (Nursing) to the Governance Committee. During the Governance Review, she advised that she was developing her strategic vision for Nursing and Midwifery Governance Structures and will be reviewing the Terms of Reference for the Nursing and Midwifery Governance Forum.

4.4 Integrated Governance

The context for integrated governance in healthcare has its origins in 2004[15] when NHS organisations were urged to; move governance out of individual silos into a coherent and complementary set of challenges, require boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery, require the development of robust assurance and reporting of delegated clinical and operational decision making in line with well-developed controls and to be supported by board assurance products, which provide board members with a series of prompts with which to challenge their objectives and focus.

The Good Governance Institute 'Integrated Governance Handbook' recognised that in simple terms there is only one governance and that this is the primarily the business of the board. Apart from clinical practice at the point of patient care the board is the key place where all the aspects of governance (clinical, quality, cost, staffing, information etc.), come to play at the same time.[16] Effective governance requires that organisations do not dissipate the composite whole into fragments that never realign. In 2006, integrated governance was defined as the 'systems,

[15] NHS Confederation Conference Paper by Professor Michael Deighan [and others]: '*The development of integrated governance, NHS Confederation*', May 2004 as summarised by John Bullivant.
[16] *Ibid*.

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processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations'.[17] Key to delivering a good governance model and to delivering these systems, processes and behaviours is an Integrated Governance Strategy or Framework which clearly articulates the organisation's assurance and accountability framework.

The Trust's strategy for integrated governance is defined in the Integrated Governance Framework 2017/18 – 2020/2021 (the Framework) which is marked as 'Draft' however, during the Review, the Board Assurance Manager confirmed that the Framework was endorsed by the Governance Committee. The document is set out in a standard strategy format and details the organisation's governance arrangements to implement an integrated governance model that links financial governance, risk management and clinical and social care governance into one framework. The Framework describes the overarching governance structure, the accountability and responsibility arrangements for the management of governance including the role and function of Trust Board and Board Committees. The document clearly indicates that the Framework should be should be considered with other key Trust documents, in particular the Trust's Risk Management Strategy. It is less definitive about the integrated governance assurance and accountability arrangements (complaints, serious adverse incidents, findings of independent review/inquiries and case management reviews etc.) to Trust Board and the operational/directorate governance reporting arrangements through to the Senior Management Team and this may have added to the perception of dual reporting lines. The Framework should provide an electronic link to the key supporting strategic and policy documents, which have been reviewed and described below Sections 4.5 – 4.22.

The Governance Controls Assurance standard requires that there are clear accountability arrangements in place for governance throughout the organisation. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation provide an overview of Trust Board and Board Committees, however, as described above these documents by their nature only provide generic descriptions of roles and responsibilities of Executive Directors. The Reviewer acknowledges the challenges in maintaining a dynamic Integrated Governance [Framework] as roles and responsibilities of Committees and individuals evolve and change as a result of a number of factors. Senior managerial functions have changed since the Framework was developed in 2017, therefore the extant version does not accurately reflect the accountability or current roles and responsibilities of the Executive Directors.

It is recommended that the Strategy/ Framework is reviewed as a matter of urgency and provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Strategy/Framework provides electronic links to related /key corporate Trust Strategies and Policies and extant guidance where applicable.

[17] DoH 'Integrated Governance Handbook' 2006.

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The review of the Strategy/Framework will have to take account of any revision of the Trust Board's governance structures which will underpin good governance through an improved assurance and accountability framework, as recommended above (Section 4.1.9). [18]

4.5 Social Care Governance

The Integrated Governance Strategy indicates that the Executive Director of Social Work has a dual role also holding operational responsibility for the Children and Young People's Directorate and is responsible to the Chief Executive for the Trust's social work/social care governance arrangements and for the delegation of statutory social care functions and corporate parenting responsibilities. Within the Trust' High Level Governance Structure (Integrated Governance Framework) the only current reference to a social care governance framework is a forum entitled 'Social Work and Social Care Governance Forum'.

In the early stages of the Governance Review the Executive Director Social Work shared a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019. The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework. This Framework also identifies roles and functions within the Directorate and across the interfaces. This key document should be cross-referenced and electronically linked with the Integrated Governance Framework (see above).

A review of Trust Board agendas and minutes confirm that the Annual Delegated Statutory Functions Report is tabled at a public meeting of the Trust Board meetings prior to submission to the Health and Social Care Board. During the Review, the Trust Board Chair outlined the process for review by the Non-Executive Directors. Minutes also confirm that the Corporate Parenting Report is also tabled at public Trust Board meetings. The Executive Director also presents a report every two months to Trust Board which provides a summary of activity and developments. Also tabled is the Corporate Patenting Report.

Senior stakeholders expressed some concern regarding Adult Safeguarding arrangements. ***It is recommended that this area of concern is reviewed to identify any potential risks/gaps in control or assurance in this area.***

4.6 Being Open

As outlined in Section 4.1, the Trust Board play a key role in ensuring the organisation operates effectively and with openness and transparency. The National Patient Safety Agency (NPSA) first issued the 'Being Open Framework' national

[18] SHSCT '*Integrated Governance Framework'* Figure 2 page 23.

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guidance in 2005.[19] In recognition of changing context in NHS organisations and the altered context, infrastructure and language of patient safety and quality improvement they revised the guidance in 2009. The revision was also based on a listening exercise with healthcare professionals and patient representatives on how organisations could strengthen the principles of being open.

The Trust does not have a current Being Open Policy but has researched existing policies and has established a working group to develop the guidance. The Chair of the IHRD DoH Being Open Sub Group is scheduled to attend the Trust to meet with Board members. The Trust has also participated in the IHRD Programme Duty of Candour/Being Open Stakeholder Events.

The NHS Leadership Academy indicate that effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation. A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners as the primary means by which it meets policy and/or regulatory requirements. As such the Board holds the interest of patients and communities at its heart.[20]

Sir Robert Francis defined openness, transparency and candour as follows:

- Openness: enabling concerns to be raised and disclosed freely without fear and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.[21]

Post-Francis, the Care Act 2014 introduced a Statutory Duty of Candour for health and social care providers in England i.e. an organisational Duty of Candour.[22] Duty of Candour was introduced by legislation for NHS Trusts in England and the IHRD Report 2018 calls for a Statutory Duty of Candour to be enacted in Northern Ireland (Recommendation 10). The DoH IHRD Duty of Candour Workstream and Being Open Sub Group have delivered a series of stakeholder events to build on the principles of 'being open'. They are also considering the implications of the proposed individual Statutory Duty of Candour. Recommendation 2 seeks for a sanction of "criminal liability" to be attached to a "*breach of this duty and criminal liability should attach to the obstruction of another [member of staff] in the performance of [his/her duty]*". The Duty of Candour is inextricably linked to the policy of 'being open'.

[19] On 1 June 2012, the key functions of the NPSA were transferred to the NHS Commissioning Board Special Health Authority.[5], later known as NHS England. In April 2016, the patient safety function was transferred from NHS England to the newly established NHS Improvement.
[20] Leadership op cit. Section 2 Roles of the Board – Ensure Accountability
[21] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Sir Robert Francis, February 2013
[22] The details of the duty were subsequently set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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In respect of developing Trust policy on 'Being Open', the Reviewer is aware that the DoH IHRD Being Open Sub Group are currently developing regional 'Being Open' policy/guidance with an aim to publish within the current financial year. It is envisaged that this policy directive/guidance will deliver the spirit of the IHRD recommendations on openness and candour until such times that a statutory duty of candour is enacted. The Trust will also have to consider the implication of the implementation of Recommendation 69 (i) and ***it is recommended that the Trust consider the implications of implementing the Regional 'Being Open' framework which includes appointing and training an Executive Director with specific responsibility for 'Issues of Candour'***. [23] The Trust has Non-Executive representation on the ALB Board Effectiveness Sub Group where this matter is being considered.

4.7 Controls Assurance

The requirement to report annually on Controls Assurances standards ceased in April 2018 and the Trust was required to put in place internal assurance arrangements for each area previously covered by the former Controls Assurance Standards. The Chief Executive outlined the importance of continuing to monitor and review action plans and advised that a Controls Assurance Group had been constituted, he advised that 2018/19 would be a transition year. The Terms of Reference will be reviewed for 2019/20.

The Controls Assurance Group is currently a sub-group of the Senior Management Team and was initially chaired by the Chief Executive and is now chaired by the Director of Finance, Procurement & Estates. The remit of the Group is to drive an implementation plan in the Trust to deliver on the governance framework and assurance model in relation to Controls Assurance. The implementation plan is linked to the annual Governance Statement and Mid-Year Assurance Statement reporting cycles.

Stakeholders raised a concern about a potential gap in the management of medical devices and equipment at operational level. The Reviewer was advised that there were Equipment Controllers in Acute Services. ***It is recommended that the Trust undertakes an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation***.

It is the responsibility of the Controls Assurance Group to monitor compliance with best practice guidance, policies and legislation previously contained within the former Controls Assurance Standards regime and agree the process for ensuring assurance on this to the Chief Executive and the Board (and onwards to the Department of Health, where required). Therefore, it is a key component of the Trust's systems of internal control and the integrated governance and assurance framework.

[23] IHRD, Loc.cit. Recommendation 69(i). Volume 3, Page 93.

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It is recommended that the Trust develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.[24] This will offer additional assurance that core standards and related legislation and statutory duties are embedded across the organisation (see also Section 4.1 Health and Safety Management and Medical Equipment as above). This development would also underpin the Risk Management Strategy and the Medical Directorate should provide corporate oversight of this process.

4.8 Risk Management Strategy

Managing risk is a key component of good governance and is fundamental to how an organisation is managed at all levels. The Trust's extant Risk Management Strategy is dated January 2014, and the Strategy was based on extant guidance at the time. It is linked to the Corporate Objectives and Values. In line with the Controls Assurance Standard, it contains a Risk Management Policy statement and key definitions including a brief definition of risk appetite. Since 2013/14 there has been more guidance available on how risk appetite should be applied in HSC organisations (see Draft Risk Management Strategy below). As the Strategy was approved 2014, it does not accurately reflect the roles and responsibilities of Committees and Executive Directors within the current governance accountability arrangements. Analysis and evaluation of risk are based on the Regional Matrix including the Regional Impact Table 2013, however, the Regional Risk Matrix was revised in 2016.

At the commencement of the Governance Review 2019, the Reviewer was made aware of a Draft Risk Management Strategy for 2019 – 2022 developed by the Interim Assistant Director of Clinical and Social Care Governance. This version of the Strategy is pending completion of the Review before further consultation and submission to Trust Board for approval.

The Draft Strategy (2019-2022) is based on ISO 31000: 2018, current legislation, and regional and national guidance. It contains a narrative detailing the roles and responsibilities of staff and related processes associated with risk management, including the management of risk registers and the process for the escalation and de-escalation of risk. It defines the role of the Senior Management Team in respect of risk management, including the management of the Corporate Risk Register. The Draft Strategy also provides a clear description of the risk assessment process utilising the most recent version of the Regional Risk Matrix.

The Draft Strategy outlines the role of the Medical Director as the Executive Director with delegated responsibility for risk management and clinical and social care governance. The role encompasses:

- The effective co-ordination of clinical and social care risk and governance – specifically this relates to the functional areas of patient/service user safety,

[24] The Trust's Health and Safety team have developed a Health and Safety risk audit tool. Comprehensive risk audit and assessment tools have been developed by other HSC Trusts for example Risk Audit and Assessment Tool Northern Trust (RAANT).

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patient/service user liaison, litigation, effectiveness and evaluation, risk management and multi-disciplinary research;
- The provision of risk management support to Trust Directors via the clinical and social care governance structures of the medical directorate;
- Clinical and social care governance support for clinicians, nursing staff, social workers and allied health professionals;
- Regional and national initiatives related to clinical and social care governance are addressed and brought to the attention of appropriate staff;
- Regular clinical and social care reports/information are brought to the Governance Committee (in line with the Governance reporting framework) and to Trust Board.

The Draft contains a detailed Risk Acceptance Framework which includes a Risk Appetite Matrix.[25] The Trust must take risks in order to achieve its aims and deliver beneficial outcomes to stakeholders. Risks should be taken in a considered and controlled manner and exposure to risks should be kept to a level deemed acceptable to the Board. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to achieve its strategy over a given time frame. Risk Appetite levels should form the background to the discussion in relation to risk and are nationally considered under four headings; risk to patients, organisational risk, reputational risk and opportunistic risk. Nationally Trusts make an annual statement on risk appetite.

The Draft Risk Management Strategy should show clear links with the Integrated Governance Framework (which should also be revised and updated as outlined in Section 4.4).

It is recommended that the Draft Risk Management Strategy is submitted for approval as a matter of urgency.

It is recommended that the Trust Board consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register. This will enable risks throughout the organisation to be managed within the Trust's risk appetite or where this is exceeded, action taken to reduce the risk. This item is also addressed in the Trust's Board Assurance Framework at June 2019.

Some stakeholders identified a current gap in provision of risk management training, which stakeholders have also highlighted that this is in part as a result of the lack of the resources to provide training in-house. Therefore, ***it is also recommended that a risk management training programme should be developed and delivered to underpin the publication of the approved strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers*** (see Section 4.9 and 4.23 Corporate Clinical and Social Care Governance structures).

4.9 Risk Registers including Board Assurance Framework

[25] Good Governance Institute **Risk Appetite** for NHS Organisations: A **Matrix** to support better risk sensitivity in decision taking. January 2012.

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The Trust is required to be aware of its risk profile and to identify the key areas for investment in risk treatment. The Risk Management Strategy defines the framework for risk registers that comprises both the Directorate and Corporate Risks which underpin the Board Assurance Framework. Well managed risk registers are dynamic documents which log, quantify and rank the risks that threaten the Trust's ability in achieving its aims and objectives.

Currently risk registers are based on Word and Excel documents. The Trust has recently purchased the Datix Risk Register Module which will facilitate risk register reporting at Directorate and Corporate levels.

4.9.1 Board Assurance Framework

In line with extant guidance the Trust has a Board Assurance Framework.[26] The purpose of the Framework is 'to ensure that the Board can be effective in the delivery of [the Trust's] objectives'. An Assurance Framework seeks to identify and map the main sources of assurance in the Trust and co-ordination them to best effect. The Board Assurance Framework articulates the principal risks to achieving the Trust's objectives and enables the Board to assure itself that all significant risks are being managed effectively and appropriate controls are in place and are place. The Board Assurance Framework should be reviewed by Trust Board on a six-monthly basis. Analysis of Trust Board agendas indicate that the Framework was tabled in June 2018. A review of the minutes does not reflect levels of discussion.

The Board Assurance Manager, on the delegated authority of the Chief Executive, is responsible for maintaining the Corporate Risk Register and Board Assurance Framework and for supporting the Governance Committee and Trust Board in ensuring the provision of regular risk reporting and monitoring information and assurances.[27]

The Board Assurance Framework provides an organisational context and makes a clear link with the delivery of corporate objectives and is underpinned by the Integrated Governance Framework, Risk Management Strategy, Corporate Risk Register and Controls Assurance processes. The figure in Section 5 of the Board Assurance Framework demonstrates the combined 'top down' and 'bottom up' approach to identifying principal risks.

The Board Assurance Framework contains a high level summary of the Corporate Risk Register, which is also reviewed by the Governance Committee of Trust Board (see below). The Revised Risk Management Strategy provides clarity on the relationship between the Board Assurance Framework and the Corporate Risk Register and in particular the decision-making process on how risks are escalated to the Board Assurance Framework. The format of the Board Assurance Framework has been revised and now includes information on levels of assurance and where independent assurance had been provided i.e. by and Internal Audit or externally by RQIA or Royal College visit etc.

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[26] DHSSPS *'An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies'.* March 2009. www.dhssps.gov.uk

[27] SHSCT *'Draft Risk Management Strategy'* April 2019.

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An assessment of the effectiveness of each control measure, based on a RAG rating is included in the Framework.

4.9.2 Corporate Risk Register

The Trust's Corporate Risk Register is linked to the Corporate Objectives as identified within the Trust's Corporate Plan 2017/18 – 2120/21. The Corporate Risk Register is reviewed on a quarterly basis by the Governance Committee. It is the remit of the Senior Management Team to ensure that there is an effective risk register and that risks are escalated to the Board Assurance Framework as appropriate.

The Senior Management Team review the Corporate Risk Register on a six weekly basis and stakeholders advised that there was robust debate and challenge at these meetings. In addition, the Chief Executive advised that at a Directors workshop during 2018/19 members had undertaken an in-depth analysis of two risks (Infection Prevention and Control (HCAI) and Cyber Security) which had proven to be a useful exercise. It was agreed by the Governance Committee in May 2018 that the Committee would also consider one/two risks in detail on a rotational basis. The minutes of the Governance Committee (September 2018) demonstrate this new approach and capture discussion and challenge by the Non-Executive Directors.

The Chief Executive further advised that the Corporate Risk Register template had also been revised during 2018/19 and that the Senior Management Team continue to monitor the process and seek ways to improve the format e.g. defining the risk description. Senior stakeholders indicated that the revised format was more user friendly. It was noted however, that currently the recorded risk rating is the inherent risk and not the residual risk after the control measures have been applied.

The Register provides a useful summary table of Corporate Risks and in line with best practice the summary table contains trends on the movement of risk levels. It provides a summary of the Risk Assessment Matrix and does not currently contain the impact grid as reviewed by the HSCB in 2016 (see Risk Management Strategy Section 4.8). The Reviewer acknowledges that when the Corporate Risk Register is underpinned by Datix Risk Register software a further review of the risk register process will be required.

It is recommended that the management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.

4.9.3 Directorate Risk Registers

Each Directorate maintains a risk register which is owned by the Director. The Directorates each have a forum in which these Risk Registers are monitored. The Directorate Risk Register is owned by the Director. The Directorate Risk Registers

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form the basis of the 'bottom up' approach to identifying principal risks as outlined in the Board Assurance Framework.

Directorate Risk Registers are currently in different formats. ***It is recommended that a standardised Directorate risk register template is considered when Datix risk register module is implemented.***

4.10 Management of Adverse Incidents including Serious Adverse Incidents

4.10.1 Management of Adverse Incidents

The Trust Policy supplied to the Review is entitled 'Incident Management Procedure', a 'working draft' dated October 2014. The Procedure sets the context for the management of incident reporting as a fundamental element of the Trust's Risk Management Strategy and focuses on the need to monitor trends and learn from incidents and it does promote the Trust's corporate priorities and values including the need for staff to be open and honest and act with integrity. However, the Procedure does not accurately reflect the current roles and responsibilities of Trust Officers in respect of the management of adverse incidents. The Reviewer was advised that the 2014 Policy was not reviewed as work was ongoing to develop a Regional Adverse Incident Policy which is due to be issued during 2019/20.

The Procedure provides guidance on the risk assessment process which should be applied to all incidents at the time of occurrence to decide the level of investigation that is required. This links with the Procedure for the management of Serious Adverse Incidents outline below.

Adverse incident reports form a key component of the Clinical and Social Care Governance Report to the Trust's Governance Committee. The Governance Committee review incident reporting including serious adverse incidents on a quarterly basis. Senior stakeholders indicated that the report format had been revised during 2017/18. However, the Interim Assistant Director Clinical and Social Care Governance advised that she was currently reviewing and developing the content of reports to provide higher quality intelligence (not just data) that is high level but also allows for appropriate scrutiny and challenge by the Board of Directors.

The Trust mechanism for recording all incidents is Datix web using an electronic incident form. The Trust uses Datix Common Classification System (CCS) codes for the categorisation of incidents. During 2018/19 work was undertaken to align Datix systems and the use of Datix CCS codes across the Region as part of the 'Delivering Together Programme'.[28] The Datix alignment programme was completed by March 2019. Stakeholders advised that there were currently insufficient staff in the Corporate Clinical and Social Care Governance team (Medical Directorate) to quality assure adverse incident data (see Section 4.23.1). This is a function undertaken in the other HSC Trusts. The Reviewer was informed that there were a significant number of incidents in the category 'In Review' which needs to be addressed in the short term.

[28] Department of Health, "*Health and Wellbeing 2026: Delivering Together",* October 2016.

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It is recommended that a Trust flow chart is developed that underpins the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.

It is recommended that the corporate oversight of the management of adverse incidents is strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)

4.10.2 Serious Adverse Incidents

The extant procedure for the management of Serious Adverse Incidents (SAIs) is the Health and Social Care Board (HSCB) Regional 'Procedure for the Reporting and Follow up of Serious Adverse Incidents'[29]. Stakeholders indicated that the Directorates have adopted local procedures for the management of SAIs and some concern was expressed about a lack of consistency in approach. Stakeholders also advised of a backlog in SAI Reports being submitted to the HSCB within the required timescales which requires urgent attention.

The Reviewer is aware that the Regional Procedure is subject to imminent review to take account of the recommendations of the IHRD Report in respect of the Management of SAIs. There is also a significant link with the work of the Being Open Workstream (see Section 4.6). Three of the DoH IHRD Implementation Workstreams are considering these recommendations which are summarised as follows;

- *Duty of Quality ALB Board Effectiveness and Quality Clinical and Social Care Subgroups* – learning and trends should form programmes of clinical audit (See Section 4.15), relevant reaching authorities should be informed if findings of investigations show inadequacies in current medical or nursing education programmes and information from investigations should be assessed for potential use in training and retraining, Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths are brought to the immediate attention of every Board member (see Section 4.23.1);
- *SAI Workstream* – family engagement, investigations should be subject to multi-disciplinary peer review, each Trust should publish Policy detailing how it will respond to and learn from SAI related patient deaths and each Trust should publish in its Annual Report details of every SAI related patient death.
- *Education and Training* – training in SAI investigation methods and procedures should be provided to those employed to investigate and clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours (see Section 4.21 Medical leadership);

[29] Health and Social Care Board '*Procedure for the Reporting and Follow up of Serious Adverse Incidents'*, November 2016.

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- *Preparation for Inquest and Death Certification* – Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation (See Sections 4.15 and 4.21).

It is appreciated that for some of these recommendations there have been challenges in defining the objective or principle of the recommendation and for some a Regional approach is being sought, however there are some early indications of travel in terms of family engagement and scrutiny and challenge (see also Section 4.23 for resource implications).

To enable the Trust meets the action required, the following is recommended.

It is recommended that the Trust constitutes an SAI Review Group and/or SAI Rapid Review Group which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.

It is recommended that the Trust develops a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.

The Governance Coordinator highlighted the investment in a recent SAI training programme delivered by an external provider. She also advised that the training programme provided staff with a wide range of investigation tools, techniques and best practice guidance.[30] ***It is recommended that the Trust develops a SAI RCA/Systems Analysis toolkit based on the training provided by the external provider.***

Given the importance and focus on family/service user engagement, IHRD workstreams have been considering the role of an SAI Review Liaison Officer. Discussions during IHRD workstream meetings have highlighted some of the challenges for staff fulfilling this role (emotional resilience, communication skills and time commitment), in addition to existing work commitments. ***It is recommended that the Trust considers how the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process would be implemented.***

4.11 Health and Safety Management

The Trust has a Health and Safety at Work Policy dated December 2014 which was due for review by December 2016. The Policy indicates that the Chief Executive has delegated responsibility for establishing an monitoring the implementation of the Health and Safety at Work Policy to the Director of Human Resources and Organisational Development with support from the Assistant Director of Estates/Head of Health and Safety. More recently, the responsible was delegated to

[30] Training was provided by CLS Educate @ www.clseducate.com

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the Director of Finance, Procurement and Estates and the Health and Safety Team are currently part of the Estate Risks and Sustainability Department and report to the Director of Finance and Estates.

The Team aim to maintain a high visibility and engagement in clinical, non-clinical and social care areas. System based on HSG65 (Health & Safety Executive Managing for Health and Safety) and is centred around: Plan, Do, Check and Act.

The Trust has a Joint Health and Safety Committee and the Chair rotates between the Lead Director and Trade Unions. The Terms of Reference for the Committee are included in Appendix 1 of the Health & Safety Policy and are therefore circa 2014. The membership is indicated as being made-up from Directorate Representatives and Representatives from Trade-Union/Professional Bodies within the Trust. The quorum is four members however, the Terms of Reference do not specify the requirement for an equal representation of staff and management. The current Terms of Reference do not indicate the reporting arrangements to Trust Board and the extant Governance Committee Structure (Integrated Governance Framework Figure 1) does not clearly indicate the reporting and assurance arrangements of this key statutory Committee (See Section 4.2.6). The Lead Director advised that a review of committee membership and agenda was planned. ***It is therefore recommended that the Health and Safety Committee review their Terms of Reference and submit to the relevant Board Sub Committee for approval.***

The Annual Health and Safety Report 2017/18 was provided in evidence to the Review. The 2017/18 Report was presented to the Governance Committee for noting and with a request for feedback on the content and structure of the report so that reports going forward can be reviewed and be as 'meaningful and informative' for the Committee as possible.

Stakeholders indicated that attendance at training remains a challenge and this was highlighted in the Annual Report. The 2017/18 Report indicates that Health & Safety audit activity was constrained due to a lack of resources from within the Committee.

The Health & Safety Team have developed a Health & Safety audit tool to evaluate Trust compliance with key areas of health and safety legislation including; accountability, risk assessment, Display Screen Equipment, Management of Violence and Aggression and Slips, Trips and Falls. The aim of the audit is to provide assurance to the Lead Director for Health and Safety. The audit tool is based on a three year cycle which aims to audit all areas of the Trust and cover 15 legislative areas. All audit results are presented to the relevant Director, the Health and Safety Committee and the Governance Committee.

The audit tool is emailed to all Heads of Service (100) within the Trust. The Heads of Service are then required to issue the question sets to their Departmental/Service/Team leads for completion and scoring. Responses are completed on the basis of full compliance, partial compliance or no compliance options for each question. The return rate for the audits at year end 2018 were 78%. Results are collated by Directorate, indicating that 22% of Heads of Service did not

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submit a return. The Health and Safety Team complete verification audits of 10% of returned audit compliance levels.

From the interviews with stakeholders, the Reviewer found a limited knowledge of the purpose and use of this audit tool. The audit process was evaluated during 2018 using Survey Monkey. A total of 22 Heads of Service responded and some issues were identified including the challenges of competing priorities. This is a useful audit tool which ***could be further developed and used to form the basis of a more comprehensive risk audit and assessment tool as highlighted above (see Section 4.7).***

Senior stakeholders identified some concern regarding assurance of compliance with Health and Safety risk assessments across the organisation. In particular, it was believed that an assessment of compliance with the Control of Substances Hazardous to Health (COSHH) Regulations was required. ***It is recommended that an organisational COSHH audit is undertaken during 2019/20 to be completed before end March 2020.***

4.12 Management of Complaints

The Trust has a Policy for the Management of Complaints which was approved in July 2018. The Policy indicates that the Medical Director is responsible for ensuring that the complaints procedure and approach ensures that appropriate investigations and actions have been competed before a response sent following a formal investigation of a complaint. Further, the Policy indicates that the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. However, the Policy clearly indicates that the Medical Director must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken. Stakeholders indicated that the line of corporate oversight by the Medical Director's Office was now less robust than the Policy envisaged and that this should be revisited.

The [Interim] Assistant Director for Clinical and Social Care Governance is required to work with the Trust's 'operational, executive and corporate Governance leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness' of changing practice, taking regard of evidence based practice, lessons learned from reviews, complaints, incidents and public inquires and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priorities for action.

The Corporate Clinical and Social Care Governance Team receive complaints and log them into the Datix Complaints module and they are then forwarded to the Operational Directors. The Policy indicates that the Corporate Complaints Officer (CCO) is responsible for screening service user contacts and determining if these are enquiries or complaints and should facilitate either resolution of the enquiry or complaint or facilitate the complainant in the use of the formal complaints procedure. ***It is recommended that the remit of this important role (CCO) is reviewed in line with the Trust's Complaints Management Policy and as part of the***

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recommended Corporate Clinical and Social Care Governance Department restructure (this will include consideration of resources required to deliver this improvement, see also Section 4.23). The Policy also indicates that the CCO should alert the Directorate governance teams to significant issues. ***It is recommended that the process of screening of complaints is reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors***.

The Operational Directors are responsible and accountability for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. There is some variation across the Directorates in approach to the management of complaints. At interview, senior stakeholders outlined continuing challenges in meeting response timescales and in particular within those areas where a larger volume of complaints are received e.g. Acute Services. It was also identified that some complaint responses remained outstanding for significant periods of time. Senior stakeholders also indicated that there was a significant variation in the quality of responses received for review by the Director, with many responses being returned for further consideration/amendment. This was cited as a particular challenge when a cross Directorate response was required or when an accurate oversight of complaints involving independent sector providers was required.

A recent NI Public Services Ombudsman Report confirmed the concerns expressed by internal stakeholders reiterating the importance of timeliness in responding and the requirement for clear cross directorate/sector linkages, accurate grading of complaints and corporate oversight to ensure that appropriate linkages are made with the Regional SAI process.

There are some good examples of complaints management for example, the CYPS governance team undertook an IHI Quality Improvement Personal Advisors programme which resulted in significant improvement the management of complaints within the Directorate. The improvement initiative included service user feedback on the complaints process from 353 complaints investigated and responded. The Directorate also undertook an audit from January 2017 to December 2018 from which learning has been identified. A process to improve the management of complaints should be replicated across the organisation to ensure equality in response to service users.

Directorate staff were positive about the use of the Healthcare Complaints Analysis Tool (HCAT) which was developed by the London School of Economics Report July 2018. HCATs is an analytical tool for codifying and assessing the problems highlighted by patients and their families of advocates in letters of complaints. The HCAT codes are considered by Trust staff to be more effective than the Datix CCS Codes and the Reviewer has been advised that it is possible to add an additional field to Datix to capture both sets of codes to facilitate data analysis.

As has been indicated in other key areas of governance (incidents, legal services and M&M), stakeholders indicated a gap in sharing lessons from this process and the need to create a more robust process (see also Section 4.20).

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It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a short term 'task and finish group' to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).

4.13 Litigation Management

The Policy and Procedure for the Management of Litigation Claims provided for the Review indicates that it is operational from November 2018 and due for review in 2021. The Policy does not indicate that it is in draft status however, the Reviewer has been informed that the draft Policy has been submitted to the Policy Scrutiny Committee for approval and subsequent circulation.[31] The Policy provided in evidence states that the Executive Medical Director is the designated officer with responsibility for Clinical Negligence claims and Coronial Services and the Director of Human (HR) and organisational Development (OD) is the designated Director with responsibility for Public and Employer Liability Claims. Each have the associated delegated financial authority accordance with the Trust's SFI and Authorisation and Approvals Framework. From a managerial perspective the Litigation Management Team/Department is the responsibility of the Director of HR and OD.

The Policy is a best practice document that clearly articulates the roles and responsibilities of key stakeholders, line managers and staff and in particular the Policy highlights the need for shared learning, being as honest and open with patients/service users and their relatives/carers and the need for staff support in the event of their being involved with a litigation process.

The Litigation team provide reports to the Governance Committee. The Litigation Manager attends Interface Meetings with the Directorates. Stakeholders advised that the opportunities for learning from claims and Inquests both internally across the organisation and externally with the wider health service could be improved.

The Head of Communications is notified of pending Coroner's Inquests and Preliminary Hearings. The system will readily allow for compliance with IHRD Recommendation 50 (*The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved),* when it is formally implemented through the IHRD Implementation Programme.

Senior stakeholders highlighted the proposal to appoint two Medical Leads for litigation management (see Sections 4.21). The paper outlining proposals for Medical Leadership was presented to SMT in June 2019. It is proposed that there will be a Medical Lead for Coroners Services who will work with the Legal Services Manager and Clinical Directors to provide professional and clinical input into the management of Coroner's cases. The role will include the following areas of responsibility; support in the process of obtaining statements from involved staff and advise on action to be taken, support in deciding from whom statements and reports

[31] Policy Checklist indicates that the November 2018 Policy Version supersedes the 'Policy for the Management of Litigation and Claims 2007'.

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should be sought and review reports and provide a direct liaison and efficient communication with the Coroner's Office. In this respect, the Medical Lead and Legal Services Manager should follow IHRD Recommendation 51 (*Trust employees should not record or otherwise manage witness statements made by Trust Staff and submitted to the Coroner's Office*). As above, more definitive guidance on this Recommendation will be issued via the IHRD Implementation Programme.

The Medical Lead will also provide an extremely important role in supporting Trust staff who are to appear in the Coroner's Court which may mean attending that Court. The Reviewer, acknowledges the challenge that fulfilling this role will entail i.e. balance the Duty of Care to support staff during a stressful experience with any perception that such support could be viewed as unduly influencing staff. Therefore, clear rules of engagement should be developed.

A second Medical Lead for Litigation Services is also proposed. The area of responsibility is not defined in the Medical Leadership Review paper, however, it is understood that this Medical Lead will provide support for the management of professional negligence (clinical negligence) claims and provide a separate line of support and leadership within the Trust's Legal Services Management arrangements.

Stakeholders raised the issue of the management of legal services within the Trust being compliant with IHRD recommendation 36 ~ *Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.* The Reviewer is aware that the IHRD Death Certification and Preparation for Inquest Workstream have debated this requirement and are currently considering how this recommendation should be implemented in practice. However, the proposed arrangement for appointment of two separate Medical Leadership Management posts is a model which is currently viewed as being reasonable.

Senior stakeholders advised that given the existing workload, delegated authorisation framework for clinical (professional) negligence and the proposed model of providing medical leadership that the Legal Services team would be best placed with the Corporate Clinical and Social Care Governance team, Medical Directorate.

It is therefore recommended that the management of Legal Services should be reviewed. This recommendation should be taken in the context of any DoH policy directive arising from the IHRD programme which may indicate a best practice model for the management of serious adverse incidents, clinical negligence and Trust Coronial Liaison Services.

4.14 Policies, Standards and Guidelines

4.14.1 Policy Scrutiny Committee

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The Trust has a Policy Scrutiny Committee. Stakeholders involved in the Committee indicated the challenges in maintaining oversight of review and renewal dates given the sheer volume and diversity of Trust Policies and Procedures. Another challenge is that on occasion the Trust Policy has reached the review date and there is a delay as new legislation or regional guidance is pending and/or a regional policy is being developed. In these instances the Trust should consider amending the Policy Procedure Checklist to indicate an extension to review/revision date due to external factors. Some policy authors advised the Reviewer of delay in time from submission to date of approval and dissemination of policies, especially when external deadlines were a factor. During the Review it was noted that version control was not always robust indicating the potential for staff to be working from a dated or draft version of a policy or procedural document. ***It is recommended that the Trust consider options for an electronic policy and procedure management system that is accessible, easy to navigate, contain a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.***

4.14.2 Management of Standards and Guidelines

Each HSC Trust is accountable and responsible for ensuring that clinical standards and guidelines are effectively managed so that the required recommendations are embedded within local health and social care practice.

The Trust has a process for the management of standards and guidelines which is reliant on both Corporate and Directorate based systems. Standards and guidelines are logged onto the Trust's database system centrally by the Corporate Governance Team and then forwarded on a weekly basis to Directorate Governance Co-Ordinators, Pharmacy Governance and the Medical Directors Office. Each Directorate have developed their own processes for the management of Standards and Guidelines. During the Review stakeholders expressed concern that were there was evidence that Standards and Guidelines were disseminated, however, there was a lack of assurance that they were being implemented as subsequent audit of practice had not always taken place (see Section 4.15). This concern was reiterated by the Chairman and Non-Executive Directors, who identified that this was an area that required focus.

Internal Audit carried out an audit of the Management of Standards and Guidelines during May 2015 when 'Satisfactory' assurance was provided. They audited the process again in September 2018 and provided a Limited level of assurance identifying that although the Trust had good controls to record corporately the receipt and subsequent dissemination of Standards and Guidelines to the directorates there is no corporate overview and reporting of the Trust's overall compliance against Standards and Guidelines.

The Internal Audit also identified weaknesses in relation to the completeness of data held on the Trust's Standards and Guidelines Register and limited ongoing audit/follow up of compliance (as above).

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Stakeholders described the challenges in managing the large volume of standards and guidelines that are received from external agencies. During 2017/18, a total of 230 guidelines were received from external agencies, 23 were not applicable to the Trust of the remaining 207 there were 39 that were not applicable to Acute Services. Senior stakeholders identified the challenges in managing standards and guidelines which have cross directorate applicability.

In April 2012, the Trust established a Corporate Standards and Guidelines Risk and Prioritisation group. The aim of this group was to provide a corporate forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines across all of its care directorates. The Reviewer understands that the Group was stood down in January 2017 to be replaced by monthly meetings between the Corporate Assistant Director Clinical and Social Care and Directorate Governance leads.

All of the Directorates have systems in place for the management of Standards and Guidelines. Acute Services have a robust system in place for the dissemination of Standards and Guidelines which represents a best practice model. The system was developed and is managed by a Patient Safety and Quality Manager (Standards & Guidelines) who is a NICE Scholar and a member of the Acute Services Clinical and Social Care Governance Team. The system includes a Standards and Guidelines Operational Procedures Manual, a reporting schedule, process maps including a process map for clinical change leads and an Accountability Reporting system for Acute Services. The downside of this system is that it is person dependent. The Patient Safety and Quality Manager also identified that the lack of clinical audit in providing assurance that standards and guidelines had been implemented was a systems issue.

Other challenges include identifying a clinical/managerial lead for guidelines – as there is an apprehension surrounding taking on the responsibility/accountability for change lead role.

Positive assurance statements go directly back to HSCB via the Corporate Clinical and Social Care Governance team. Previously they would have been approved by SMT prior to issue. ***It is recommended that a level of corporate oversight is reinstated (in line with the Assurance & Accountability framework S4.1).***

An 'Accountability Report' of the Trust's compliance with Standards and Guidelines had previously been reported to the Governance Committee on a twice yearly basis. ***It is recommended that the Accountability (Compliance) reporting arrangement is reinstated***.

The Trust will be required to comply with IHRD Recommendation 78 ~ *Implementation of clinical guidelines should be documented and routinely audited*. The challenges in respect of clinical audit are outlined in Section 4.15. It is anticipated that as part of the final stage of the IHRD Implementation Programme Assurance Framework HSC organisations will be required to provide independent

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assurance of compliance with policies and procedures arising from the recommendations (see also Section 4.15 and 4.23).

The Trust, as a matter of urgency, should review the overarching corporate arrangements and resources to provide assurance regarding the effective management of Standards and Guidelines and to facilitate a risk based approach from the triangulation of data from incidents, complaints, claims, service reviews, Morbidity and Mortality reviews and Clinical Audit.

It is recommended that the Trust take the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director. The Reviewer understands that the IT system currently used within Acute Services may not have the capacity to deal with Trust-wide information.

4.15 Clinical Audit

The Trust's Clinical Audit Strategy was presented to the SMT on 20 June 2018 and was then presented to the Governance Committee on 6 September 2018. The Strategy defined clinical audit as 'a quality improvement cycle that involves the measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes'. Clinical audit is an integral part of the good governance framework.

Senior stakeholders advised that Internal Audit had provided Clinical Audit with a 'Limited' assurance level. The Clinical Audit Strategy outlined the strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit activity would be appropriately managed and delivered. The paper clearly outlined the key issues and challenges for the organisation which include; ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance and ensuring that there is a sufficient number of staff in the corporate clinical audit team and in the operational Directorates to support the delivery of the approved clinical audit programme. The Strategy also describes the prioritisation of clinical audit in line with Healthcare Quality Improvement Partnership (HQIP) proposals that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

Clinical Audit will have an increasing and key function in providing corporate assurance that IHRD Recommendations have been implemented. Clinical Audit and the Morbidity and Mortality Process are intrinsically linked (see Section 4.16). Clinical Audit will be required to provide assurance that clinical standards and guidelines have been implemented (IHRD Recommendation 78 as outlined in Section 4.14). Also Recommendation 76 ~*Clinical standards of care, such as patients might reasonably expect should be published and made subject to regular audit*. Clinical audit will also be required to provide assurance of organisational compliance with clinical standards in IHRD Paediatric Clinical (Recommendations 10-30) for example, patient transfer, on-call rotas and clinical record keeping.

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Stakeholders described the dilution of the clinical audit function over a period of time, this experience is similar to that of other HSC Trusts. The Clinical Audit Strategy 2018, identified that the current [administrative] staffing levels in the corporate Clinical Audit and M&M team and operational directorates as insufficient to support and deliver the clinical audit work programme. The Reviewer would concur with this statement and would add that the demand on this governance function is set to increase significantly as described above. This is covered in more detail in Section 4.23. Clinical and Social Care Governance Structures.

The Medical Director has also identified resource issues in the paper entitled 'Medical Leadership Review submitted to SMT in June 2019 (see Section 4.21). The appointment of a Clinical Standards and Audit Lead who will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies is key.

Stakeholders advised that there was a need to demonstrate more robust linkages between clinical audit and quality improvement and the management of serious adverse incidents. ***It is recommended that the integration between quality improvement and the integrated governance function is reviewed to ensure optimum connectivity.***

The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.

It is also recommended that the Clinical Audit Committee is reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure (Assurance & Accountability Framework Section 4.2.6 and Appendix 2.

Given the potential increase in focus and demand on clinical audit as outlined above ***it is recommended that the resource implications are reviewed, see Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).***

4.16 Clinical Outcomes - Morbidity and Mortality (see also 4.21 Medical Leadership)

Morbidity and Mortality (M&M) reviews are primarily a tool for identifying opportunities for system level improvement. There was a focus during the IHRD Inquiry into the rationale and mechanics of M&M Review and the significant role this process has in improving outcomes through learning. In November 2016, the DoH issued guidance on a Regional Mortality and Morbidity Review (RM&MR) process. The aim of the guidance was to provide specific direction for M&M leads and a regional approach as to how M & M meetings should be established, structured managed and assured. RM&MR is hosted on the Northern Ireland Electronic Care Record (NIECR)

As part of the 2018/19 Annual Internal Audit plan, Internal Audit carried out an audit of M & M during October to December 2018. The SHSC Trust was one of four

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Trusts audited during this period. The Reviewer has noted that the audit focused specifically on the mortality aspects of this guidance. Internal Audit provided a Limited Assurance in respect of the M&M processes. The Internal Audit Report recognised that there were processes however, timescales for Consultant review and discussion at M&M groups was not routinely followed and some deaths had not been reviewed or discussed. Internal Audit did recognised from their observational audit (attendance at three meetings) that deaths were discussed in detail with a level of robust and challenging professionalism among teams visited. Senior stakeholders within the Board of Directors noted an improving culture in the ethos of utilising M&M for shared learning within the organisation.

As a result of the Internal Audit review of four Trusts, a number of concerns have been raised regionally about the adequacy of the regional M&M process and in particular the need for significant investment in order to ensure M&M regional processes are fit for purpose, especially around Learning Lessons. Trust stakeholders have also identified a lack of resources (see also Sections 4.15 and 4.23.1). If the appropriate staff are to attend specialty meetings, they need time out to learn (as indicated above this is also a recommendation from the IHRD Report), this was identified as a particular challenge for non-medics without job plans. Trust senior stakeholders identified that the lack of multidisciplinary participation was a concern and that that was partially as a result of the culture.

In addition, there is a risk in the context that all deaths must be reviewed, that sufficient time will not be spent on those deaths which provide the most opportunity for learning. This would require a screening/risk assessment process to be built into the regional process. There is no central IT system's overview, so the Trust cannot interrogate the system to generate reports and this lack of reporting functionality was a concern raised by Trust officers.

The Trust established an Outcome Review Group, which met for the first time in June 2018. The remit of this Review Group is to provide an assurance that all hospital deaths are monitored and, reviewed and reported, in line with regional guidance and to ensure that lessons learned and actions are implemented to improve outcomes. It is recommended that the Outcome Review Group (see also Board Governance Structures Section 4.1.9 and Appendix 2).

M&M Chairs have a key function in delivering the RMMR process. Within SHSCT they are responsibility for setting and maintaining the agenda for M&M meetings and for determining, supporting and developing patient safety inputs. They also have a monitoring role which includes; attendance, timely completion of screening templates and medical staff participation in Case Presentation. An M&M Chairs meeting has also been developed with the purpose of informing the ongoing development of M&M meetings and processes. The M&M Chairs should report to the Outcome Review Group.

Within the Trust, stakeholders highlighted the need for IT and administrative support for the process. With the right investment administrative staff could also reconcile deaths with SAIs thus providing another line of assurance that the process is being implemented. The Internal Audit Report indicates that the minutes and presentations

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at M&M meetings are held centrally by the Corporate M & M team and Clinical Audit team (see Section 4.23.1).

The M&M Review Process is a core element of the Trust's integrated governance arrangements and patient safety framework. The Clinical Audit/M&M team within the Medical Directorate are a crucial element of the Process. The Outcomes Review Group is an important component of the Trust's assurance framework. I***t is recommended that they are adequately resourced and supported to ensure optimum outputs and clinical engagement. The support will include the development of administrative systems for the central suppository of minutes and attendance logs***.

4.17 Raising Concerns

The Trust's Policy for raising concerns is entitled 'Your Right to Raise a Concern' (Whistleblowing) and is based on Regional guidance. There is no indication of the date the Policy was approved/became operational on the Front Cover. The Lead Director is the Director of Human Resources and Organisational Development.

Board Effectiveness guidance increasingly highlights that the Board of Directors have a role in creating the culture which supports open dialogue. This should include Directors personally listening to complaints, concerns and suggestions from patients and staff, and being seen to act on them fairly (see also Section 4.6 Being Open). The Board should be assured that there is a framework which indicates how staff should raise their concerns and a key element is a clear whistleblowing policy, with support and protection for bona fide whistle blowers. The Reviewer was advised that a Non-Executive Director has been nominated to take a lead in this area.

The aim of the Trust policy is to promote the culture of openness, transparency and dialogue which at the same time; reassures staff that it is safe and acceptable to speak up, upholds patient confidentiality and contributes toward improving services, demonstrates to all staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards. The Policy also aims to assist in the prevention of fraud and mismanagement and contains specific guidance and contact details in this respect. The Trust Policy compliments extant Professional Codes and Guidance on responsibilities in raising concerns and clearly states that it is not intended to replace professional codes and mechanisms which also questions about professional competence to be raised.

The Director of HR advised that a gap in awareness training had been identified which would be addressed. She also advised that the use of advocates would be implemented in the medium term. Stakeholders who had participated in investigation cases indicated that this process was another source of learning for the organisation. The Policy contains a template entitled 'Record of Discussion regarding Confidentiality' which is a very useful tool in those situations where confidentiality is an issue for the member of staff raising the concern.

4.18 Information Governance

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The Trust has identified that safeguarding the Trust's information is a critical aspect of supporting the delivery of its objectives. Effective management of information risk is a key aspect of this. The Trust has arrangements in place to manage the risk including; an Information Governance Strategy incorporating Framework, Framework, a Personal Data Guardian to approve data sharing (Medical Director and Director of CYP), a Senior Information Risk Owner (Director of Performance and Reform) and Information Asset Owners in place to reduce the risk to personal information within the Trust and training and advice provided to ensure they were aware of their responsibilities. The Senior Information Risk Owner (SIRO) provides an annual report to the Governance Committee which provides a summary of key aspects of the role, the minutes confirm that the Report was last presented in February 2019.

The Information Governance Strategy incorporating Framework is dated 2014/15 – 2016/17 and is underpinned by a suite of policies, procedures and guidance. The Information Governance Policy is dated January 2015 with a two year default for review. ***The Policy should be reviewed to take account of extant legislation and guidance in particular General Data Protection Regulations 2018.***

Information Governance breeches are required to be reported in line with Trust's Incident Reporting Procedure. Stakeholders have identified that learning from information governance incidents should be included in the Lessons Learned Forum (Section 4.20).

As identified in Section 4.1 Freedom of Information and Data Protection summary compliance data is reported to Trust Board on a quarterly basis to ensure completion within statutory timeframes. An information sharing register is in place which records the details of all episodes of sharing of Trust data with other bodies. Information governance training is mandatory within the Trust.

The Trust had taken action to ensure it was prepared for the General Data Protection Regulations (GDPR) in May 2018. Internal Audit provided 'satisfactory' level of assurance in relation to General Data Protection Regulations (GDPR) Readiness within the Trust during the 2017/18 audit cycle.

Cyber Security remains as a 'High' risk rating on the Corporate Risk Register.

4.19 Emergency Planning and Business Continuity

The Trust has a Corporate Emergency Management Plan incorporating Major Incident and Business Continuity. The Plan was approved by Trust Board in January 2013 and was revised during 2018/19 and is dated 15 February 2019. The lead Director is the Executive Medical Director. The Emergency Planning Policy is dated November 2015, approved by SMT on 9 December 2015 and circulated in February 2016 by the Medical Director. The Business Continuity Policy is dated 2012. An Annual Report on Emergency Planning and Business Continuity is submitted to Trust Board.

The Trust's Controls Assurance Emergency Planning Framework self-assessment has identified that the Trust is largely fully compliant with the core standard. Some

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actions have been identified including; provision of appropriate resourcing for the Emergency Planning Office; developing an ongoing exercise programme/schedule at directorate and corporate level and a process for implementing actions arising from major incidents/exercises. A training needs analysis is required to identify any gaps in the key competencies and skills required for incident response including chemical, biological, radiological and nuclear defense (CBRN) training. These actions will be monitored by the Trust's Controls Assurance Group (See Section 4.7).

Stakeholders indicated that the development of Business Continuity plans at Directorate level could be improved.

4.20 Shared Learning for Improvement

All of the stakeholders expressed the need for HSC organisations to learn from service user experience and from the analysis of adverse incidents, complaints and claims. The commitment to learn is expressed in the Trust's 'Values' and Corporate Objectives. In the Trust's strategic priority 'Promoting safe, high quality care' the Trust has stated its commitment to 'be a learning and continually developing organisation, where professional standards, best practice and learning from experience share how we improve our services'.

The Trust has a Lessons Learned Forum whose purpose is to provide a corporate cross directorate interface for the identification and sharing of lessons learned from incidents (including near misses), complaints and litigation cases. The Forum is also responsible for identifying areas for improvement in the Trust' management of adverse incident and complaints and if appropriate propose system changes and to provide challenge and scrutiny to the Trust's adverse incident processes. The Forum members are responsible for presenting potential sharing lessons learned from their service areas and for assisting in disseminating the learning within their respective service areas. Stakeholders suggested 'casting the net wider' in respect of sources e.g. systems failures identified in Whistleblowing cases and HR Grievance and Disciplinary investigations (subject to the same rules of working within information governance parameters, maintaining confidentiality and limitations due to ongoing legal processes). Senior stakeholders wanted to see a stronger link between 'Lessons Learned' and Quality Improvement. (See also Section 4.1.9 Board Governance structures.)

Senior stakeholders advised that at times it seemed like the processes for learning were disparate and there was a lack of connectivity for example the learning identified through M&M and learning provided for the Forum. Stakeholders were therefore were keen to ensure that as various Sub Groups are developed within the Trust's integrated governance/assurance framework that duplication of purpose is minimised and the process for shared learning was escalated and disseminated through the proposed Assurance and Accountability framework (Section 4.1.9 and Appendix 4).

During the Review a meeting of the Lessons Learned Forum was held and stakeholders stated that it had been an excellent agenda and provided the organisation with a valuable opportunity to learn. However, the stakeholders were

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also disappointed at the lack of attendance by medical staff. It is recognised that time to learn is a challenge for clinical staff. This was recognised in the IHRD Report and Recommendation 66 states *'Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours'*. The Education and Training Workstream have interpreted clinicians in the boarder term to include nursing, Allied Health Professionals and Social Workers. (See also Medical Leadership Section 4.21). Stakeholders were keen to explore alternative forms of sharing learning through e.g. annual safety events, learning lunches, learning letters and safety newsletters shared on Trust's intranet.[32]

Stakeholders also indicated that the challenge and scrutiny function within the Forum's Terms of Reference in respect of the management of adverse incidents had not yet been embedded. However, there may be a more appropriate forum for the Trust to undertake the scrutiny challenge and quality assurance of serious adverse incidents (see Management of SAIs Section 4.10).

In reviewing the Terms of Reference the Trust should consider how the Forum could contribute to the implementation of IHRD Recommendation 40 'Learning and trends identified in SAI investigations should inform programmes of Clinical Audit' (see also Management of SAIs Section 4.10).

4.21 Medical Leadership

Medical leadership was last reviewed in the Trust in 2011 and as the related paper indicates, given the length of time since this review and the changes in the health and social care landscape it was agreed that a further review and potential revision of the medical leadership form and function was required.

The findings were presented to the SMT on 11 June 2019. The 'case for change' highlighted three key areas:

- Performance of Frontline Teams;
- Providing a Link from Ward to Board;
- Supporting and influencing Service Planning.

The review emphasised the importance of implementing a Collective Leadership Model and the need to move on from a concept of command and control leadership. The review report also recognises that due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. Engaging doctors within the collective leadership model therefore is crucial.

The review process included an independent survey of medical leaders which was carried out to identify the barriers and enablers. Many of these findings reflect the comments from stakeholders during the Governance Review and included the need to clearly define the roles and accountabilities of medical leaders and provide protected time to deliver in their roles and greater integration with operational management teams.

[32] An example of a Trust serious adverse incident/never event learning letter 'Nevermore' is available to view at www.yorkhospitals.nhs.uk

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The Medical Leadership Review indicated that if the proposals were approved, all Medical Leadership management posts would be vacated and reappointed collectively.

To support the Medical Director who carries responsibilities in a wide area including; Medical Professional Governance, Clinical and Social Care Governance, Quality Improvement and Audit and Infection Prevention and Control, it is proposed that two Deputy Medical Directors should be appointed. One of the post holders, Deputy Medical Director Quality Improvement will focus on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, developing a clinical governance strategy and participating in education and training programmes as required. The Deputy Medical Director will work with the [Interim] Assistant Director Clinical and Social Care Governance in a Collective Leadership model and will provide stronger corporate integrated governance oversight and leadership.

As outlined in Sections 4.14 and 4.15 Standards and Guidelines and Clinical Audit and Sections 4.13 Coroners Service and Litigation Management and Section 4.16 M&M the investment in these Medical Leadership management roles is core to delivering clear accountability arrangements that will provide a robust assurance framework for effective integrated governance. In addition, the structure will facilitate the Trust meet the recommendations arising from the IHRD Implementation Programme. To achieve maximum outputs from the Medical Leadership model, the Trust should recognise the need to provide additional administration and clerical support (see also Section 4.23). [33]

4.22 Governance Information Management Systems

The Trust currently uses a commercial risk management/patient safety software programme called Datix. Datix is used in all of the Health and Social Care Trusts and the Health and Social Care Board. The Trust currently uses the Incident reporting, Complaints and Claims modules and has just purchased the Risk Register module.

Stakeholders advised that the Clinical and Social Care Governance Coordinator, Mental Health Service had developed statistical reports/Datix dashboards for his own and other operational Directorates which was a much welcomed tool to support data analysis and provision of governance reports.

All of the stakeholders in the Governance and Patient Safety Department and the Directorates who were interviewed were keen that the collective software system was utilised to the maximum capacity to support the patient safety/integrated governance agenda. They were also keen to explore the advantages that more advanced patient safety software can achieve for example Datix Cloud IQ. This is

[3333] SHSCT 'Medical Leadership Review' June 2019. Section 14.11, page 29.

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currently being considered by the IHRD DoH Clinical and Social Care Sub Group in respect of the implementation of Recommendations 67, 68 and 80 (see below).[34]

The Reviewer is aware that the IHRD DoH Clinical and Social Care Sub Group have identified regional issues in respect of Recommendation 80 ~ "*Trusts should ensure that health care data is expertly analysed for patterns of poor performance and issues of patient safety*". Through the initial benchmarking data the DoH workstream identified that HSC Trusts reported various levels of data analysis and various approaches including expert analysis through Data Triangulation Groups. Strong links with existing systems i.e. QI data were identified (dashboards and statistical run charts) and some data from traditional clinical coding e.g. CHKS. Regional variance with commercial systems on trial or in use were also identified e.g. two Trusts use Alamac which consists of 4 models including analytics and governance reporting, service redesign and improvement and operational performance improvement and governance which includes real time data analysis e.g. heat map.

An indication of the direction of potential regional guidance in this matter is not available at present. The DoH workstream have accepted that Encompass will be integral in the future, however it is accepted that they will have to consider a short to medium term solution and are seeking to influence the Regional Data Strategy. During this Review Trust stakeholders also identified issues with the existing ICT infrastructure and the expert and administrative support required to provide the required level of information to provide assurance to Trust Board (see also Section 4.1 and Section 4.23). ***It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations.***

To ensure that the Trust maximises it's information for integrated governance it is ***vital that a dedicated Datix systems administrator who can ensure the quality of data provided as this has been identified as a gap at present*** (see also Clinical and Social Care Governance Structures below).

4.23 Integrated Governance Structures

4.23.1 Corporate Clinical and Social Care Governance, Medical Directorate

The Executive Medical Director is the Executive Lead for Corporate Clinical and Social Care Governance. The Corporate Clinical and Social Care Governance Team is managed by the [Interim] Assistant Director for Corporate Clinical and Social Care with the support of one very recently appointed Senior Manager (Head of Patient Safety & Improvement). The Team support a large range of integrated governance functional areas including; delivering the Risk Management Strategy, incident reporting including Serious Adverse Incident reporting, complaints, patient

[34] Recommendation 67 ~ ' *Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed'*. Recommendation 68 ~ '*Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining'*. Recommendation 80 ~ '*Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety'*.

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safety data and reporting on Clinical and Social Care to the Governance Committee of Trust Board.

Stakeholders advised and as is described in the Sections above that some of the functions are 'light touch' and limited to initial screening or signposting (e.g. complaints). The Reviewer was advised that the Management of Infection Prevention and Control would transfer to the Interim Director. In addition, during the review, the management of Clinical Audit and the M & M system was also transferred from within the Medical Directors Office to the Interim Director and as a result of the Review potentially the management of legal services (with exception of HR legal services),[35] the Board Assurance Framework and Corporate Risk Register would also be considered for transfer.

This centralisation of corporate integrated governance functions under the leadership of the Executive Medical Director represents a best practice 'good' governance structure and will be crucial for effective delivery of the proposed integrated governance assurance and accountability framework (see Section 4.1.9). The revised corporate clinical and corporate governance structure will create a more robust first line of assurance to the Board of Directors on the systems of internal control (including gaps in control and assurance). However, there are concerns for the staffing of this resource in respect of meeting the current demands and more crucially in meeting the increased demands of delivering a more robust assurance framework and in delivering the improvements required in the systems of internal control (Sections 4.4 – 4.22).

The Reviewer has benchmarked the existing corporate clinical and social care governance structure within the Trust with the Northern Health and Social Services Trust (NHSCT) structure who have a similar organisational profile and successfully implemented a robust accountability and assurance framework as recommended above in Section 4.1. [36] The NHSCT corporate governance structure is described below.

The Trust (SHSCT) have recently appointed a Senior Manager (Head of Patient Safety Data and Improvement). This post holder will focus on safety, quality and innovation as key drivers to deliver improved outcomes for patients and clients. This post is responsible for managing the timely and effective provision and communication of a corporate quality and safety analysis service.

The post holder will be responsible for setting the strategic direction for a range of analysis services provided at corporate organisational level within the Trust. This will include Patient Safety, Clinical Audit, Mortality & Morbidity and Trust clinical guidelines, in line with statutory requirements and national, regional benchmarks, peer accreditation frameworks and standardising Trust best practice.

[35] As outlined in Section 4. 13 the management of legal services is subject to review by the IHRD DoH Preparation for Inquest and it is anticipated that there will be a Regional Policy Directive on the management of clinical (professional) negligence and Trust Coronial Services.

[36] Information kindly provided by the NHSCT Assistant Director Governance & Risk Management. The Reviewer recognises that the NHSCT portfolio includes the management of Health and Safety.

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The Patient Safety Manager will support the Head of Patient Safety Data and Improvement. The post holder is one of the original Institute for Healthcare Improvement (IHI) HSC Safety Forum members and maintains and updates the Forum Extranet and contributes to regional work. There are examples of best practice improvement initiatives in this area for example the Patient Safety Falls Walking Stick and the Pressure Ulcer Safety Cross. The Patient Safety Manager undertakes a large volume of data analysis activity supporting the Trust's Patient Safety Programme. The role is currently supported only by one Band 3 (24 hours). Therefore, this service is dependent on a single manager which is not sustainable. The post holder has limited time to use his expertise at ward/department level in quality improvement initiatives for example Sepsis6.

Clinical Audit (including M&M) is managed by an Acting Band 7 Manager who during the Review demonstrated commitment to providing a quality service and provided insight into the challenges of delivering both current and future clinical audit and M&M activity. The team to support Clinical Audit has reduced following the Review of Public Administration (RPA) and currently consists of a B5 WTE x 1 and Band 3 WTE x 3 plus 1 part time.

As outlined above, (Sections 4.15) clinical audit is 'back on the radar'. The role of the team is to support the delivery of the Trust's clinical audit programme which includes key national, regional and local drivers for clinical audit (described as 'top-down') balanced against directorate/service priorities and the interests of individual clinicians (bottom-up) initiatives.[37] The team screen audit proposals prior to registration. The post holder advised that there were also challenges in relation to supporting National Confidential Enquiry into Patient Outcome and Death (NCEPOD) activity which is currently person dependent within the Trust and needs to be re-focused.

Also as above (Section 4.15) the Clinical Audit team have a key role to play in delivering the Regional M&M Review system. Within the current resource there is very limited time for support for M&M Chairs which ideally would include pre and post meeting support and support for the Chairs Forum which meet on a quarterly basis. The rolling audit calendar is a particular challenge as support is required for six meetings at the same time.

The third key challenge for the Clinical Audit team with the current resources is supporting the linkages with quality improvement, the management of standards and guidelines (Section 4.14) and Serious Adverse Incidents (Section 4.10) and providing the SMT and Trust Board with assurance that improvement in practice has been implemented and sustained.

Stakeholders have indicated resource challenges in supporting the Trust to respond to the demands arising from the existing work plan of the Regulation and Quality Improvement Authority (RQIA) e.g. thematic reviews. In addition, the Corporate Clinical and Social Care Governance team will have to prepare for the increase in

[37] Healthcare Quality Improvement Partnership (HQIP) propose that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

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demand as the RQIA fulfil their functions in providing external assurance of compliance with the policies, procedures and guidelines arising from the final stage of the IHRD Implementation Programme, the Assurance Framework. The various workstreams and subgroups are currently working toward this final stage and more explicit information is not available at this time however, the Trust should seek feedback through their Director's Oversight Group from their workstream representatives. In addition, there is also likely to be more Internal Audit activity in respect of integrated governance functions arising from this same phase of the IHRD Programme.

The Governance Coordinator provided insight into core elements of the Clinical and Social Care Governance agenda including; complaints management, adverse incident management (including SAIs) and the use of Datix. She highlighted the lack of the corporate resource required to provide systems-wide quality assurance of these systems.

The range of functional areas for the Corporate Clinical and Social Care Governance team is wide and if proposed corporate governance functions are further integrated these functional areas will increase significantly. In addition to the day-to-day remit of the functional areas, the Clinical and Social Care Governance Team have to respond to a number of external demands for example the DoH IHRD Workstreams and stocktaking exercises, the RQIA (as above) and an ever increasing number of FOI and Media Enquiries. Normally these activities are required in very tight timeframes.

It is the opinion of the Reviewer and senior stakeholders, at director level that the corporate clinical and social care governance function has been under resourced over the past number of years. This underfunding represents a lack of investment in staff and the necessary information technology systems to support a good governance structure.

To deliver a similar portfolio of corporate clinical and social care governance functions the NHSCT have an Assistant Director Governance & Risk Management supported by three Senior Managers for;

- Risk Management;
- Quality, Standards and Learning;
- Assurance, Data and Systems Management.

The Risk Management function is supported by three managers (Band 6 and 7 excluding their Back Care Managers) and 13 support staff (Band 5 x 2, Band 4 x 3, Band 3 x 6 and Band 2 x 1). The Quality, Standards and Learning Function is supported by three managers (excluding their Health and Safety Manager, Resuscitation Officers and Research and Development Manager) and six supporting administrative staff (Band 5 x 1, Band 4 x 4 and Band 3 x 1). The Assurance, Data

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and Systems Management function is supported by three managers and 5 administrative staff (Band 4 x 2 and Band 3 x 3).[38]

It is recommended that as a matter of urgency the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is proposed that there should be a Senior Manager for Clinical and Social Care which will include; management of Serious Adverse Incidents, Complaints and Claims and a Senior Manager for Corporate Governance which will include Risk Management, Risk Registers, Datix Administration, Controls Assurance and training (see Appendix 3). It will be essential to also consider the administrative support required to support the corporate function areas as has been highlighted throughout the report if the Trust is to meet the ever increasing level of scrutiny and demands to provide assurance to Trust Board and external stakeholders of the efficacy of its internal control systems. ***Therefore, it is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by SMT.***

Given the wider remit of the corporate team it is important that each functional area has an annual action plan/work plan which will underpin the Corporate Clinical and Social Care Governance management plan and which can be linked to Corporate Objectives and staff appraisal.

4.23.2 Directorate Governance Arrangements

It was evident that Directors had invested in their Governance structures, however, they all advised that there was still not the capacity to meet the demands of providing information and assurance to internal and external stakeholders on the wide range of integrated governance elements e.g. standards and guidelines, serious adverse incidents and complaints. Additionally, there is an ever growing demand under RQIA, FOI, Media Inquiries etc.

The extant Integrated Governance Framework requires that each Operational Directorate Governance Forum is responsible for considering all aspects of the Trust's 'Model of Integrated Governance'.[39] Each directorate have developed governance structures which includes an overarching governance forum/group with terms of reference and sub groups which vary from directorate to directorate. The Reviewer was provided with examples of the structures which show clear lines of accountability and communication lines within the Directorate e.g. Mental Health Services. Governance forum sub groups meet at varying intervals within each Directorate. There is also a slight variation in the directorate governance forum/group meeting agendas and again this is not unusual in a Trust that consists of a range of programmes of care.

[38] The Reviewer is aware that the information shared by the NHSCT represents total head count for posts and not detail of whole-time equivalents. The Assistant Director has indicated she will share further detail with the Interim Assistant Director SHSCT as required.

[39] SHSCT 'Draft Integrated Governance Framework 2017/18 – 2020/21'. Section 5 page 21 and Figure 1 page 23.

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The high level governance structure, Figure 2 in the extant Integrated Governance Framework, depicts the directorate governance forum reporting 'organisational and directorate intelligence' to the SMT. It is less clear from a review of the SMT Terms of Reference and Agendas how this operates in practice. ***It is recommended that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above (Sections 4.5 and 4.6).*** Also less clear within the Integrated Governance Framework is the role/link between the Executive Lead for Integrated Clinical and Social Care Governance (Medical Director) and the [Interim] Assistant Director for Clinical and Social Care Governance and the Operational Governance Arrangements (see also Section 4.4). This lack of clarity was confirmed by comments from stakeholders during the Review. In addition, some stakeholders indicated concern in dual reporting lines (see also Section 4.4) ***Clarification of lines of accountability, roles and reporting responsibilities should be considered as part of the recommended review of the Integrated Governance Accountability and Assurance Framework following approval of the Governance Review recommendations.***

The operational Directorates have appointed Clinical and Social Care Governance Coordinators. They fulfil a key role in supporting Directorates and in collating the Directorate intelligence. There is some variation in the demanding roles and responsibilities of the post holders which have evolved over time to meet the needs of the Directorates. There is also variation from Directorate to Directorate, in the resources allocated to provide support to the Directorate Clinical and Social Care Governance Coordinators. As above, the Directorate Clinical and Social Care Governance Coordinators and teams carry a wide range of roles and responsibilities at local level across the integrated governance functional areas and demand invariable exceeds capacity. Within Acute Services, the Director of Pharmacy has been supporting the role on a temporary basis. This should be reviewed to enable the post holder fulfil her regional role as Chair of the Regional Pharmaceutical Contracting Executive Group for Northern Ireland.

As previously outlined, there are examples of best practice across the Directorates for example work on complaints management, service user engagement and the model for dissemination of standards and guidelines. The Trust should consider how to share the best practice.

4.23.3 Interface between Corporate C&SGC and Directorates

Weekly Governance Meeting

The Medical Director and Interim Assistant Director Clinical and Social Care Governance have reinstated a weekly Governance Meeting with Directorate Clinical and Social Care Governance Coordinators. The meetings are short, lasting approximately one hour. Currently, the Medical Director where possible, either attends the meeting or joins by teleconference. The Reviewer has been advised that the rationale is to provide an opportunity for both a briefing (e.g. learning and internal safety alerts) and debriefing on newly emerging issues e.g. serious adverse incidents or complaints. These meetings meet the spirit of 'no surprises'. The

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meetings are currently held on a Thursday and members can currently 'dial in'. There is a mixed reaction to the weekly Governance meeting with stakeholders identifying that the 'dial in' facility is not conducive to debrief meetings. Stakeholders have also identified that due to the nature of Acute Services the agenda can, at times be described as Acute centric.

The interface meetings are an important development and will underpin the integrated governance arrangements of the Trust's assurance and accountability framework. It is important that this interface meeting continues and develops to meet the needs of all concerned. The Interim Assistant Director advised that the process was at an early stage and the agenda was still being tested and evolving. She further advised that maintaining the efficacy of the interface meetings had resulted in increased workload for both corporate and directorate clinical and social care governance teams. More recently, the membership has increased to include safeguarding, medicines management, litigation management and standards and guidelines and this addition was being positively evaluated.

The Trust has systems in place to brief the Board of Directors of emerging issues in a timely fashion. The output of this meeting will complement existing systems and should be further developed to provide a summary briefing note which when ratified by SMT can be circulated to the Chair and Non-Executive Directors. This will assist the Trust meet IHRD Recommendation 81 ~ *Trust's should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within he Trust are brought to the immediate attention or every Board member*.

It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.

Monthly Clinical and Social Care Governance Meeting

The monthly governance meeting provides an opportunity to consider a wider range of integrated governance issues in more detail. In light of the weekly governance meeting, ***it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.***

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Appendices

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Summary of Recommendations **Appendix 1**

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

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

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Theme/ Rec No	Recommendation	Timescale[40]
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	M
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	M
12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	S
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	S
'Being Open'		
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	M
Controls Assurance		
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	S-M
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	M-L
Risk Management Strategy		
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	S
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	M
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	L

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Theme/ Rec No	Recommendation	Timescale[40]
20	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	M-L
21	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	M
Management of Adverse Incidents including SAIs		
22	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	L
23	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)	S-M
24	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	S
25	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	L
26	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	L
27	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process.	S
Management of Health & Safety		
28	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	S
29	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	M-L
30	The Trust should undertake an organisational audit of	M

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Theme/ Rec No	Recommendation	Timescale[40]
	compliance with COSHH Regulations.	
Complaints Management		
31	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management policy.	M
32	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors	S-M
33	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	M
Litigation Management		
34	The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52.	S-M
Policies, Standards and Clinical Guidelines		
35	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.	L
36	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	S
37	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	
38	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	M-L
Clinical Audit		
39	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.	S
40	The Clinical Audit Committee should be reinstated and	M-L

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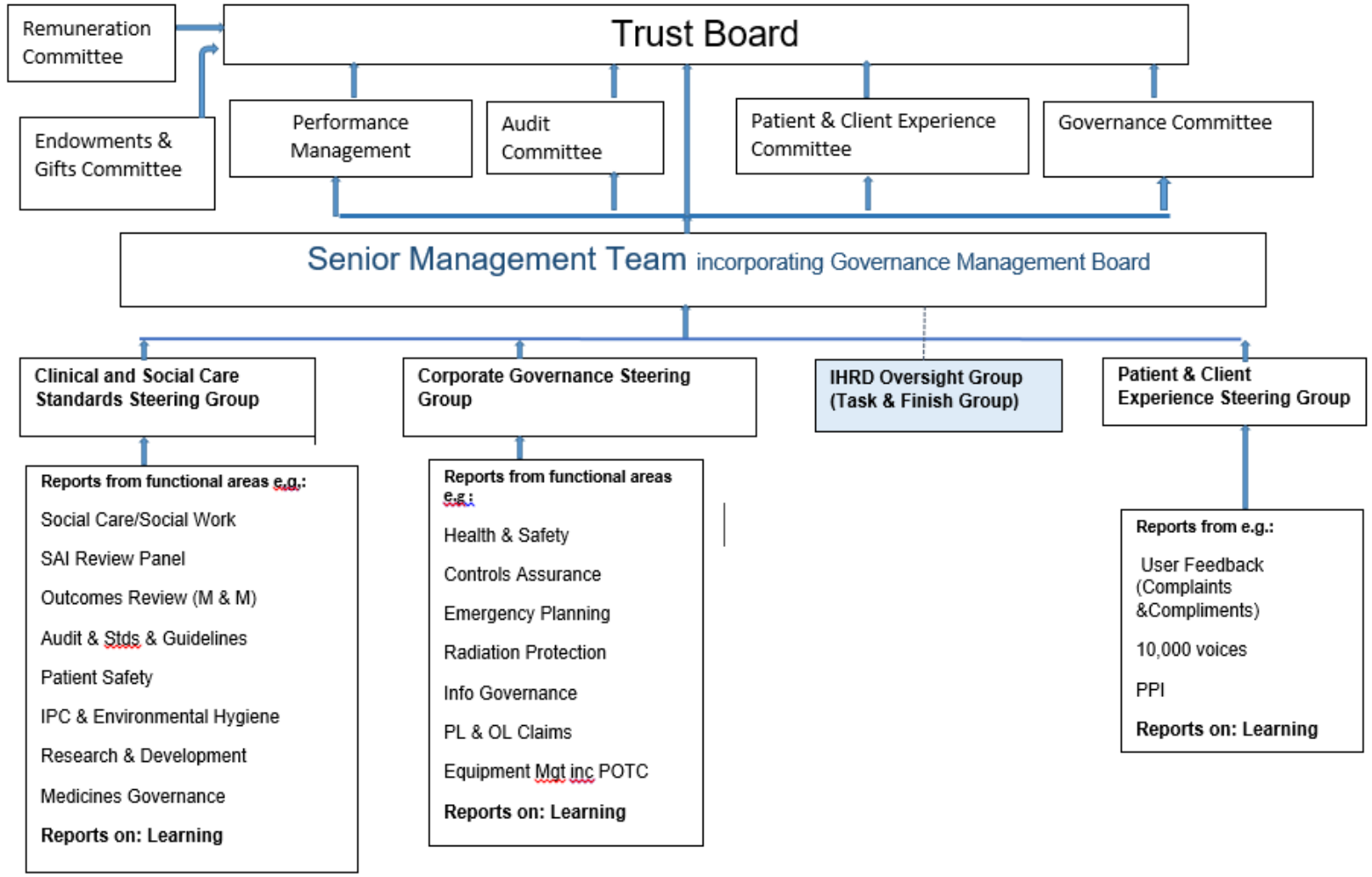
Theme/ Rec No	Recommendation	Timescale[40]
	the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1.	
Morbidity & Mortality – link with Medical Leadership below		
41	The resource implications for the delivery of the RMMR should be considered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

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Theme/ Rec No	Recommendation	Timescale[40]
47	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	S-M
48	In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	M

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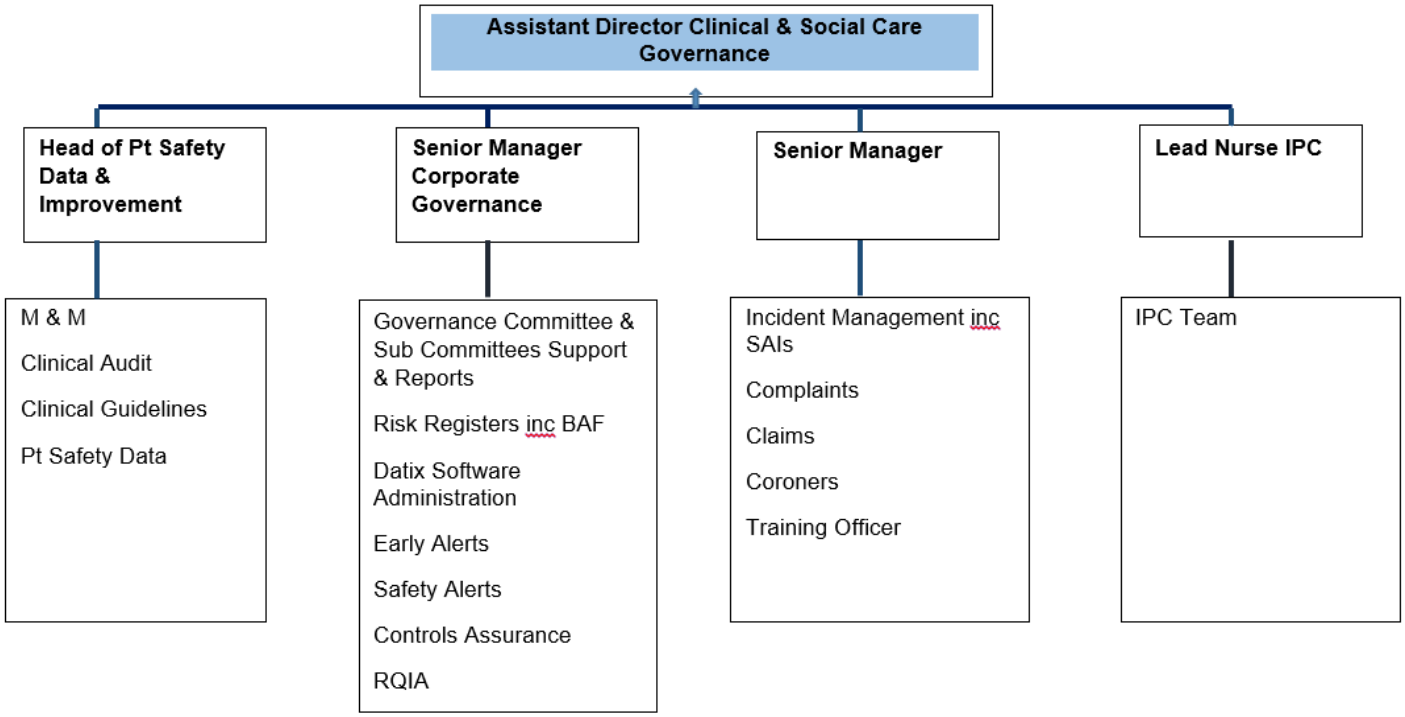
Appendix 2 Governance Committee and Sub Committee Structures underpinned by Directorate Accountability Arrangements



Directorate Accountability Arrangements

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Appendix 3 Corporate Clinical & Social Care Governance Department Structure reporting to Executive Medical Director



Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Champion Review Recommendations

No	Action Required	Person Responsible	Date for Completion	Actions Undertaken	Actions Required	Status
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020.	Chair and Chief Executive	Complete	Completed – Annual Cycle of Board reporting in place.	Complete	**Complete**
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	Chair and Chief Executive	Complete	Completed – Director of Finance, Procurement and Estates has been attending meetings since December 2018.	Complete	**Complete**
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	Chair	Complete	Completed – Chair and Board Assurance Manager meet prior to each meeting to develop and agree agenda.	Complete	**Complete**
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	CSCG safety and quality indicators have been agreed for weekly governance debrief meetings. These are shared and reviewed weekly by SLT. Information includes Governance, Nursing, Litigation and Safeguarding staff in the form of Weekly Governance Activity Reports. These include information, by Operational Directorate, on numbers of New SAIs, SAIs submitted, On-going SAIs, NIPSO cases accepted for investigation, NIPSO Reports received, Early Alerts, New Moderate/High Risk Complaints, Numbers and timescale of outstanding complaints, Catastrophic Incidents, Never Events, RQIA reports, Directors Oversight groups, Medication Incidents, Adult Safeguarding activity, Subject Access requests, Litigation, Coroner's Inquiries and Inquests, Data Breaches, Freedom of Information requests, New Standards & Guidelines received and Assurances due or submitted, Clinical Audits and Regional PIVFAIT Audits, National Audit/Confidential Enquiry participation, IPC statistics, numbers and grading of Falls and Pressure Ulcer Incidents and Approval status of Datix incidents. This report is continually under review as new key performance indictors become available as per new evidence.	Complete	**Complete**
5	The SLT Terms of Reference should be reviewed including the provision for tabling urgent papers	Dr Maria O'Kane, Chief Executive	Sep-23	Terms of Reference for SLT meetings have been approved by SLT, several changes have been made to the format and structure of the meeting including the following: • Move to use Decision Time for eletronic recording • Timings and ratings introduced to smooth agenda workflow • Agenda format reflecting item types • SLT now meets twice weekly (Formal Tuesday, Informal Thursday) • Process in place for tabling urgent papers	Complete	**Complete**

Champion Review Recommendations

6	The remit and responsibilities of SLT Governance should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of SMT Governance should also be clearly defined in the Integrated Governance Strategy	Dr Maria O'Kane, Chief Executive	Sep-23	Formal terms of reference for SLT Risk and Assurance has been formalised and agreed, meeting commenced in September 2023 and meets monthly.	Complete	**Complete**
7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	Chair and Chief Executive	Complete	The Trust revised governance structure now includes a monthly Senior Leadership Team "Risk and Assurance Meeting" which is supplied with information from three Executive Director chaired Steering Groups - "Organisational Governance Steering Group", "Standards, Compliance and Regulations Steering Group" and "Safety, Care and Quality Steering Group" (each meeting quarterly). These groups have been fully operational since September 2023. The Trust Governance Committee receives reports from each of these groups. In addition to these changes the Trust has initiated a Strategy and Transformation Committee and integrated Finance into the newly titled Performance and Finance Committee (formerly titled Performance Committee) in 2024.	Complete	**Complete**
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	Sandra Judt, Board Assurance Manager	Complete	Completed in respect of ToR and Annual Work Plans for Trust Board Committees.	Complete	**Complete**
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	Chair and Chief Executive	Complete	Director Led Oversight Groups reporting is included in the SLT Risk and Assurance meeting terms of reference and report / update on a monthly basis	Complete	**Complete**
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	Stephen Wallace, Assistant Director Systems Assurance	Complete	Complete - Terms of Reference for the Committees and Groups set up under the Revised CSC Governance Structure (referred to at recommendation 7 above), have used a standardised Terms of Reference. These will be used for Terms of Reference structure going forward as new committees and steering groups are established and terms of reference reviewed.	Complete	**Complete**
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	Chair and Chief Executive	Complete	Head of Office permanently appointed December 2023	Complete	**Complete**

Champion Review Recommendations

12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	Chair and Chief Executive	Sep-24	This will be considered in the renewed Boad Assurance and Integrated Governance Framework document that will be based on the Statutory obligations of the Trust and its aligned Trust Board approved strategic objectives	This will be considered in the renewed Integrated Governance Framework	**In Progress**
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	Deborah Hanlon, Head of Adult Safeguarding	Complete	Complete - The audit of practice in Adult Safeguarding was extended to evidence areas for improvement. Actions identified were completed and continue to be restated through training, refresher and CPD support forum. There is now a much clearer governance structure in the Trust as per the presentation in the EDSW report to Trust Board in January 2023. While there remain some areas of risk, mainly associated with the capacity issues of relevant staff across Directorates to deliver timely, quality outcomes, the linkages with Directorate Social Work Leads and developments in practice, training and support have strengthened the overall position.	Complete	**Complete**
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	Dr Stephen Austin, Medical Director - Vivienne Toal, Director HROD	Jun-24	Work commenced on Being Open along with Dr Peter McBride, DoH and will consider DoH direction on potential Duty of Candour consultation outcomes. Trust Being Open Workstream to be jointly chaired by Medical Director and Director of Human Resources and Organisational Development. SHSCT Being Open work has temporarily paused pending the outcome of the regional work being done by Dr Peter McBride. The Trust Being Open Policy paused pending the conclusion of the above.	• Trust Being Open Policy has been paused pending conclusion of Dr Peter McBride's work • Trust workstream on Being Open set up	**In Progress**
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	Catherine Teggart, Director of Finance,Procurement & Estates	Nov-23	Audit carried out by internal audit Nov 2022 and many of the recommendations have been implemented with others still in progress. Some of these recommendations however require additional resource within teams.	• Additional resources required to meet recommendation requirements - posts are currently being filled. Update 03.03.2024 A business case has been submitted to the DoF requesting additional resource to adequately manage the backlog servicing of medical equipment. Until this resource issue is resolved the risks to patients due backlog servicing of medical equipment will remain. Purchasing additional equipment to support existing and new service development will also compound the risks and issues	**In Progress**
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	Catherine Teggart, Director of Finance,Procurement & Estates	Complete	A review of the Controls Assurance process was carried out in 2022-23 alongside the establishment of the 3 new Governance Groups. It resulted in the decision to close the controls assurance group with oversight of the governance and controls reporting to the 3 Governance groups. A mapping exercise of the controls assurance areas were linked to the Governance Groups and these areas of governance are now being addressed and reviewed at Governance groups and reported to the TB Governance Committee	Complete	**Complete**

Champion Review Recommendations

17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Risk Management Strategy for 2019 - 2022 was approved. SLT agreed its temporary extension pending it being reviewed and brought to SLT for approval in June 2024.	Complete	**Complete**
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	Chair and Chief Executive	Complete	Trust Board formally agreed the Trust Risk Appetite statement in January 2024. The Trust Risk Appetite will be applied to the development of the renewed Strategic Objectives and Corporate Risk Register from 2024.	Complete	**Complete**
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Aug-24	There is no dedicated resource to implement this action. It is dependent on the availability of funding to secure the appropriate resource. Elements of this training will consider risk relating to incident management.	• Approval of proposal paper to deliver risk management training to all staff • Risk management training to be developed in relation to management of risk registers • Funding to be identifed for resource to support implementaion of risk management training programme	**In Progress**
20	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	Chief Executive and Medical Director	May-24	This requires a decision on the roles and responsibilities in the Medical Directorate and the availability of funding (either new or transferred) to implement, currently this function rests with the Office of the Chief Executive and Chair.	This requires a decision on the roles and responsibilities in the Medical Directorate and the availability of funding (either new or transferred) to implement, currently this function rests with the Office of the Chief Executive and Chair.	**In Progress**
21	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Aug-24	Work is ongoing to scope Risk Register formats at directorate / divisional level with a view to standardising these. Datix has been upgraded and development work is continuing with the appointment of the Datix Manager. The introduction of the Datix Risk Management module would ensure a standard, pro-forma of a risk register is adopted throughout the Trust.	• Full scoping of Risk Register formats at directorate / divisional level • Standardisation of Risk Register formats in keeping with Corporate model • Datix Risk Management Module to be developed	**In Progress**

Champion Review Recommendations

22	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Adoption of the business partner model for operational CSCG from 1 January 2023 has led to some progress on corporate oversight of adverse incidents. Work to strengthen quality assurance and standardisation is ongoing. SHSCT have developed an Incident Management Policy in line with the Regonal Incident Management Policy/Procedure.	• SHSCT Incident Management Policy was approved at Policy Scrutiny Committee (December 2023)	**Complete**
23	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Jun-24	An Incident Management Awareness Training package for all staff has been developed and will be part of Corporate Mandatory training. This will help to increase awareness and standardise how incidents are reported, including on Datix. It is intended that a role specific incident reviewer training package will be developed to streamline this process and strengthen the quaity of incident review, ensuring learning is addressed and shared as identified. From 1 January 2023, a Business Partner Model for CSCG commenced with operational Governance staff now reporting to the Medical Directorate. Work to strengthen the oversight and challenge function which this enables is ongoing, with a suggestion that Operational Directorate Co-Ordinators would undertake quality assurance by way of auditing completed adverse incidents reviewed.	• An audit checklist for use by the Governance Co-Ordinators will be developed and incorporated into the Incident Management Policy.	**In Progress**
24	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	Dr Stephen Austin, Medical Director	May-24	An Executive Directors' Review Group has been created and met on 23rd May 2023, 17th October 2023 and 24th January 2024. Pathway has been developed to ensure review does not delay submission of the report to SPPG if required to review report before submission. Process will be incorporated into SHSCT SAI Procedure documentation.	An Executive Directors Review Group has been created and met in May 2023, October 2023 and January 2024. Next meeting scheduled for April 2024. The roles and responsibilities of this group will be defined in the SHSCT SAI Procedure due to be presented to Policy Scrutiny in March 2024	**In Progress**
25	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Process will be incorporated into SHSCT SAI Procedure documentation.	Complete	**Complete**

Champion Review Recommendations

26	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Jun-24	A number of different models are used to examine adverse incidents and establish learning if any e.g. Fishbone, Contributory Factors, Structured Early Learning Tool. Regional work is underway to amend the SAI Framework. In the meantime SHSCT has drafted an SAI Policy and Procedure based on the current regional procedure whilst awaiting the issuing of the new regional procedure.	To be issued in June 2024, following approval at scrutiny committee	**In Progress**
27	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Service User Liaison role developed and 3 staff in post	Complete	**Complete**
28	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	Catherine Teggart, Director of Finance,Procurement & Estates	Complete	Health and Safety Committee Terms of Reference – updated 2022	Complete	**Complete**
29	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	Catherine Teggart, Director of Finance,Procurement & Estates	Complete	New 4-Year Audit Plan has been devised and is illustrated in SP103 – Internal Audit Process. This document and supporting documents, memos, forms are progressing to formal approval.	Complete	**Complete**
30	The Trust should undertake an organisational audit of compliance with COSHH Regulations.	Catherine Teggart, Director of Finance,Procurement & Estates	Complete	Within the new 4-Year Audit Plan SP103 – Internal Audit Process, audit form FM703 identifies CoSHH as a hazard requiring assessment (6.2). The suitability and sufficiency of both the general risk assessment and the CoSHH risk assessment are assessed by the H&S Officer.	Complete	**Complete**
31	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management Policy	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Band 6 Corporate Complaints Officer in post and role is consistent with extant Trust Complaints Management Policy. The SUF Policy and Procedure which incorporates Complaints Management has been reviewed, updated and issued July 2022. Roles and responsibilities are outlined within this document, including that of the Corporate Complaints Manager.	Complete	**Complete**
32	The current process of screening complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors.	Dr Stephen Austin, Medical Director	Complete	Service User Feedback Policy and Procedures has been reviewed and updated, detailing a more streamlined process for the management of complaints. Escalation of complaints currently occurs at the discretion of the corporate Service User Feedback Team and through oversight by more senior staff. Work is required to define criteria for escalation upon receipt. Complaints for which responses are outstanding are escalated to the weekly Governance meeting.	A screening template has been developed for use within the Corporate Service User Feedback Team and escalation pathway reviewed.	**Complete**

Champion Review Recommendations

33	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	Dr Stephen Austin, Medical Director	Apr-24	Since this review, the Regional Complaints Management Policy has been reviewed and circulated to regional Trusts. The SHSCT Policy and Procedure which incorporates Complaints Management has been reviewed in line with the regional Policy, updated and issued July 2022. Consideration is being given to expand the scope of the SAI Executive Directors Review group to include Complaints.	• SAI Executive Directors Review Group to consider complaints oversight within its remit	**In Progress**
34	The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52	Vivienne Toal, Director of Human Resources and Organisational Development	Dec-23	36, 51, 52 linked Linked to Regional IHRD workstreams which will be progressed as part of the Department of Health Phase 2a implemenation of IHRD recommendations.	In progress	**In Progress**
35	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder	Vivienne Toal, Director of Human Resources and Organisational Development	Complete	The Trust has developed an electronic solution hosted on Sharepoint that allows for the searching of policies and proceudures and includes electronic email notifications of policy reviews and reminders	Complete	**Complete**

Champion Review Recommendations

36	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	With effect from 01/02/2021 this corporate oversight function has been reinstated following the appointment of a Senior Manager for Standards, Risk and Learning - this post was made permanent on 15/09/2021. Quarterly S&G activity reports are now presented to Governance Committee to provide an assurance of progress as well as providing examples of any audit / Quality Improvement work SHSCT S&G Governance Officers forum is also established and meets on the 3rd Thursday of each month. A corporate work plan is in place and monitored by the Governance Co-ordinators forum to which the S&G forum is accountable to. S& G report is also presented within the weekly Corporate Governance debrief meeting which is then presented to SMT the following week. This provides a summary of newly received circulars, assurances that are pending for submission and any further requests from external bodies for updates on compliance. NICE Guideline summary for 2021/22 activity submitted to QI team on 20/07/2022 for inclusion in the annual Quality report S&G prioritisation reports are also presented to the monthly divAMD supervision meetings to identify any new activity for the preceding month as well as any barriers / challenges impeding timely progression of actions / assurances Additional resources are required to support this function. Further development of the database to support this monitoring/assurance is dependent on the availability of funding to secure additional staff	Complete	**Complete**
37	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	As per recommendation 36	Complete	**Complete**
38	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	Stephen Wallace, Assistant Director Systems Assurance	Complete	Standards and Guidelines oversight is contained within the remit of the newly established Standards, Compliance and Regulation Steering Group. This group met in March 2023 and is now fully integrated in the Trust Corporate Governance Structures reporting to both SLT Risk and Assurance Group and Trust Governance Commitee	Complete	**Complete**
39	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.	Dr Stephen Austin, Medical Director	Complete	The updated Clinical Audit Strategy was approved on 21/06/2022 and the new Clinical Audit Policy released on 01/02/2023	Complete	**Complete**

Champion Review Recommendations

40	The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1	Dr Stephen Austin, Medical Director	Complete	The new Clinical Audit Policy makes provision for a Trust wide - Clinical Audit Reference Group. A first meeting took place in March 2023. Reporting and monitoring arrangements within revised Trust Board Committee Sub-Structure reports to Trust Governance Committee via Trust Quality and Safety Steering Group.	Complete	**Complete**
41	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	Dr Stephen Austin, Medical Director	Complete	M&M chairs have been appointed in all relevant service areas and have been asked where required to incorporate any additional M&M activity above standard SPA time into their job plans. Currently the Trust operates 22 separate M&M meetings.	Complete	**Complete**
42	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central repository of minutes and attendance logs (see also Recommendation 44 and 45 below)	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Sep-24	The Patient Safety Data and Improvement Team provide facilitation for over 50% of Patient Safety Review meetings (M&M). This includes: Training and support in use of the NIECR system, administration related to the preparation, running and post-meeting action follow-up. All minutes and attendance sheets are centrally stored on a Shared Drive for all 22 M&M meetings. Facilitators also centrally monitor the RMMR process to ensure tasks are completed within timescales outlined in Regional guidelines with escalation where required. Recruitment for an additional Band 4 and 5 facilitators has been successful with start-dates anticipated in June 23. A Band 8a Service Improvement Manager and Band 5 Clinical Patient Safety Coordinator recuitment processes are underway.	• Further recruitment of a Team Manager is required when funding is identified. The Band 8a and Band 5 were not recruited as the funding was reassigned to a higher priority area i.e. Standards & Guidelines. The Head of Service post is now vacant (March 2024). Agreement with the Medical Director is required re structure/management of this team	**In Progress**
43	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Terms of Reference and Membership of the Learning from Experience Forum were reviewed in 2020/21. Further to this the Trust is expanding the remit of this function moving towards a Trustwide Learning Assurance Group in 2023.	Complete	**Complete**

Champion Review Recommendations

44 (i)	1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Jul-24	**SAIs and Adverse Incidents** Improvement have been made within the Datix system to enable SAI recommendations input which will facilitate monitoring, reporting, trend analysis and identification of barriers to implementation. Increased focus by Operational Directorate Governance teams in regards to adverse incident review has improved the backlog of these incidents on Datix. **DATIX** The Datix system has been successfully upgraded to the latest version, system compatiblity issues from this upgrade are being addressed. The Datix team are involved in scoping and supporting the transition of Complaints and Litigation from Datix Rich Client to Datix Web. They are also involved in the devlopement of the S&G and Risk Register modules on Datix, working collaboratively with the Senior Manager for Standards, Risk and Learning to implement. **Standards and Guidelines** Additional resources are required to support this function. Further development of the database to support this monitoring/assurance is dependent on the availability of funding to secure additional staff **Patient Safety** The RMMS administration process is supported by a repository for agendas, minutes and all contents required for Patient Safety Review meetings using a shared-drive. This is maintained by facilitators in the Patient Safety Data and Improvement Team. Facilitators also have access to the main Trust systems to maintain data-bases in relation to mortality. Additional administrative support posts are also being recruited. **Clinical Audit** The clinical audit function (systems and support) is in progress. Currently a phased recruitment is being undertaken to appoint 7 new posts to support clinical audit.	**SAIs and Adverse Incidents** Reporting on the SAI Recommendation functionality commenced in quarter 1 of 2023/24 and were reported to Trust Governance Committee. Ongoing work required to maintain improvement in the review of backlog of adverse incidents. **DATIX** Work required to address issues post upgrade have slowed progression of new developments within Datix. The implementation of new modules requires collaborative working with other teams, some of which are limited in terms of resource.	**In Progress**
44 (ii)	2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Two Heads of Service, a Corporate Governance Manager and a Datix Manager (permanent) and three Datix Administrators (2 temporary, 1 permanent contract) have been appointed to the CSCG team.	Complete	**Complete**
45	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Progress has been made. Three permanent Heads of Service have been appointed to the CSC Governance team i.e. Corporate Governance Coordinator HoS for SAIs, Datix and Complaints; HoS for Standards and Guidelines, Risk and Learning and Head of Service for Clinical Audit A fourth post i.e. Head of Patient Safety Data and Improvement, is now vacant. This post is subject to review. Additional appointments have been made to the Corporate Governance team with a Datix Manager, support staff and Service User Liaison staff. In addition to this additional posts will be appointed to support the new managerial posts.	Permanent recruitment in progress	**Complete**

Champion Review Recommendations

46	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	Chair and Chief Executive	Complete	Directorate CSCG safety and quality indicators have been agreed for weekly governance debrief meetings. These are reviewed and shared with SMT, Governance, Nursing, Litigation and Safeguarding staff in the form of Weekly Governance Activity Reports. This work will be supporting by the revised Trust Board Sub-Committee structures that are progressing with the establishment of a "Risk and Assurance Group", "Organisational Governance Steering Group", "Standards, Compliance and Regulations Steering Group" and "Safety, Care and Quality Steering Group". Draft Terms of Reference for each have been agreed and are meeting for the first time in March 2023. From 1 January 2023, a Business Partner Model for CSCG commenced with operational Governance staff now reporting to the Medical Directorate. Work to strengthen the oversight and challenge function which this enables is ongoing, with a suggestion that Operational Directorate Co-Ordinators would undertake quality assurance by way of auditing completed adverse incidents reviewed. In addition to this in 2023 an Associate from the Leadership Centre, undertook a review of governance systems and processes within the operational directorates. The purpose of this review was to assess if the Trust has effective governance structure, systems and process in place at Directorate level to ensure that the executive team have a clear line of sight of all aspects of quality and safety in respect of operational services. A report of the findings and associated recommendations was shared with the Trust in October 2023. In February 2024 he Associate returned to undertake a "stocktake" of the outworking of her review to provide an assurance report to the Chief Exectutive. This is due before the end of March 2024	Complete	**Complete**
47	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Apr-24	Complete - one hour weekly governance meetings with wide membership are now established and operating. A short summary template report and a detailed template report are provided to SMT weekly for information. A summary template report generated from the information discussed at the weekly governance meeting is now shared with NEDs. Feedback on this template and the approach will be discussed at an upcoming NED and CX meeting in June 2024.	Complete	**Complete**
48	In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Terms of Reference, Membership and Frequency established and operating	Complete	**Complete**





Medical Leadership Review

Revised March 2020

Senior Management Team Meeting - Date 10th March 2020





Received from SHSCT on 31/10/2022. Annotated by the Urology Services Inquiry.

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Section 1 – Medical Leadership Structure Review Framework

1. Background and Context

1. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation[1].

2. Leaders need to ensure that all staff can adopt leadership roles in their work and take individual and collective responsibility for delivering safe, effective, high-quality and compassionate care for patients and service users. Achieving this requires careful planning, persistent commitment and a constant focus on nurturing leadership and culture.

3. With this in mind good medical leadership has been identified as vital in delivering high-quality healthcare[2]. There is an increasing body of published literature that links the performance of units to levels of medical leadership[3].

4. To achieve competence in strong medical leadership doctors are required to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which modern health and social care is delivered[4].

5. The divisional medical leadership structure within the SHSCT last underwent a review in 2011 where medical leaders functions, responsibilities and accountabilities were considered. Corporate leadership roles were introduced to support medical revalidation processes, GMC responsible officer requirements and to support the development of SAS grade doctors.

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[1] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*
[2] *Warren OJ, Carnall R Medical leadership: why it's important, what is required, and how we develop it Postgraduate Medical Journal 2011;87:27-32.*
[3] *Clark J. Enhancing medical engagement in leadership. InView 2006;10:14e15.*
[4] *Darzi A. A time for revolutions – the role of clinicians in health care reform. N Engl J Med. 2009;361(6):e8.*

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6. Over time there has been an erosion of the number and impact of these leadership roles which in turn has affected morale, recruitment and retention of staff, particularly doctors. (See section 14, p 22)

7. Given the length of time since the 2011 review and the significant changes in the health and social care landscape it is now time to -re-visit, the Trust medical leadership form and function, based on an assessment of how fit for purpose it remains in a highly dynamic environment.

8. Any structure that emerges must drive a culture of effective, continually improving high quality, safe, patient / service user focussed services underpinned by quality improvement, education and research.

9. It must be open and transparent in its decision making. It must encourage all clinicians to contribute to Trust's strategic priorities and take responsibility for contributing their delivery.

2. Strategic Drivers

10. The Southern Trust must nurture a culture that ensures the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are fostered is fundamental[5].

11. The task of leaders is to ensure direction, alignment of purpose and commitment within teams and organisations. Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work.

[5] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*

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12. Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[6].

2.1 United Kingdom Regional Workforce Strategy Policy Direction

13. All NHS UK regional Departments of Heath have endorsed leadership models that require clinicians to become more actively involved in the planning, delivery and transformation of health and social care services[7,8,9,10.]

14. Current NHS Workforce Strategies are based on the concept of a shared or collective leadership model where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

15. Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services

"*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

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[6] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

[7] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*

[8] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*

[9] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*

[10] *National Leadership and Innovation Agency for Healthcare Wales*

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Department of Health England, Next Stage Review: High Quality Care for All

"Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership

"Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

National Leadership and Innovation Agency for Healthcare Wales

"Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. The Collective Leadership Model

1. The 2014 King's Fund paper titled 'Developing Collective Leadership'[11] stated the need to move on from a concept of command and control leadership to a shared and distributed throughout organisations. The report also argues that leaders must engage their colleagues and other stakeholders in bringing about improvements in patient care and transforming the way in which care is provided.

[11] West, M. A., Eckert, R., Steward, K., & Pasmore, W. A. (2014). Developing collective leadership for health care. London: King's Fund.

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2. A successful collective leadership model emerges from a conscious and intelligent effort to plan for an integrated, collective network of leaders distributed throughout the organisation and embodying shared values and practices[12].

3.1 Collective Leadership and Organisational Culture

3. The culture of healthcare, which so critically affects all other aspects of the service which patients receive, must develop and evolve to meet the needs of current and future service provision.[13]

4. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the merging culture of an organisation. [14]

5. An NHS Innovation review found that by enhancing the engagement of doctors in leadership there is potential for positive impact on both clinical and organisational performance. [15]

6. Due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. However, by engaging doctors within the collective leadership model, significant differences may be achieved which enhance performance.[16]

[12] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[13] Kennedy I. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol. 2001
[14] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[15] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p16
[16] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p33

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4. Investing In Medical Leadership

7. Clinicians across Health and Social Care must be supported to lead and drive a culture that is Compassionate, Collective, Open and Excellent and which focuses on the quality and safety of services for patients and service users and the experiences of staff.

8. This can be realised through aligning the Culture and Values of the Trust with talent management and appraisal, along with supports to help make the necessary transformation into these roles.[17].

9. Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

10. The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[18]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[19]
- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[20]

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[17] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[18] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[19] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*
[20] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*

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- A study in the Harvard Business Review (2007) provides a strong link between leadership skills and organisational performance[21]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[22]

5. Review of Best Practice Literature

5.1 NHS Medical Leadership Competency Framework (MLCF)

11. The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

12. The MLCF describes leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice, Tomorrow's Doctors and also Management for Doctors.

13. While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professionals and therefore have an intrinsic leadership role within healthcare services.

14. Doctors also have a responsibility to contribute to the effective leadership and the running of the organisation in which they work and to its future direction. The development of leadership competence is an integral part of a doctor's training and

[21] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[22] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

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learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

15. The Medical Leadership Competency Framework (MLCF) is built on the concept of collective leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

5.2 Clinical Leadership Competency Framework (CLCF)

16. The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

17. The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

18. Doctors have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

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5.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

19. The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring:
    - The team has articulated a clear and inspiring vision of the team's work
    - There is clarity about the team's membership
    - Team members agree five or six clear, challenging, measureable team objectives
    - There is strong commitment to collaborative cross-team and cross-boundary working

20. The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

21. Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

6. Current Trust Medical Leadership Structure

6.1 Medical Leadership Structure (since 2011)

22. The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

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23. The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the discontinuation of three AMD positions, the rationale for this is unclear:

- **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
- **AMD Infection Prevention and Control – *Post not retained (2015)***
- **AMD Standard and Guidelines – *Post not retained (2015)***

24. The current Southern Trust Medical Leadership Structure is outlined below

Medical Leadership Structure Today (May 2019)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *3 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*
AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair

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CAH Medicine Chair*
Trustwide Surgery Chair*
Trustwide CYPS Chair
Trustwide IMWH Chair
Trustwide MHLD Chair

* *Medicine and Surgical Specialities are supported*

7. The Case for Change

25. Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

7.1 Performance of Frontline Teams

26. There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

7.2 Providing a Link from Bed to Board

27. Medical leaders understand the complexity of modern health care services and how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[23].

[23] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

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7.3 Supporting and Influencing Service Planning

28. Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.
29. Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes. Doctors are uniquely positioned to understand the potential impact of policy or funding changes[24].

[24] Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.

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8. Consultation with Trust Medical Leadership

30. As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model (2018/19). A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix 4. A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate PA allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

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31. The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

32. Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

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9. Consultation with Trust Directors

33. Trust Directors were asked to give their views and opinions on the current medical leadership structure (2018). A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role. A summary of key findings that relate to the current medical leadership model is found in the table below (appendix 4 contains full reponses).

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

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Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

34. The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

10. Comparison with Analogous Organisations

10.1 Northern Ireland Regional Trusts

35. The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust

• Medical Director (Director for Governance, Patient Safety)
• 2 Deputy Medical Directors
• Divisional Director Structure*
• Clinical Director Structure
  • Governance and Safety Roles
	• Medical Director (Director for Governance, Patient Safety)
	• 3 Deputy Medical Directors
	• Clinical Director Structure*
	• Associate Clinical Director Structure
	  • Governance and Safety Roles

Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director (Director for Governance, Patient Safety and QI) • Divisional Medical Director Structure	• Medical Director (Director for Governance, Patient Safety and QI • 3 x Deputy Medical Directors (5 PA

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• Clinical Director Structure* • Governance and Safety Roles	each post) • 12 Divisional Medical Directors (3PA per post) • 38 Clinical Director Structure* - including CDs for litigation, coronal affairs, appraisal and revlaidation (2PA per post) • Patient Safety Lead Clinicians**(1PA per post) • Governance Lead Clinicians (1PA per post)

*Clinical Directors are equivalent of SHSCT AMD roles

** Lead clinicians are formal roles within the medical leadership structure

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Section 2 – Proposed Medical Leadership Structure

11. Medical Leadership Development and Competence

36. A supplementary paper titled Medical Management and Leadership Development will follow.

12. Medical Leadership Appointments

37. It is proposed that if approved, all Medical Leadership management posts will be vacated and reappointed collectively.

38. This paper proposes that all senior medical leadership positions commencing from August 2019 are fixed-term appointments (details found in subdivision 14 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

13. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

13.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director position, responsible for providing assurance to Trust Board those effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services,

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	support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical and social care governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	WTE
Areas of Responsibility	Medical Professional Governance, Clinical and Social Care Governance, Medical Workforce Development, Patient Safety, Quality Improvement and Audit, Infection Prevention and Control
Appointment Term	Permanent Post

13.2 Deputy Medical Directors (3 Posts Total)

Role Description	**DMD – Professional and Workforce Development (New Post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	6 PA
Areas of	• Medical Appraisal & Revalidation

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Responsibility	• Job Planning • Medical Professional Governance • Oversight of Locum Doctors • Support and Oversight of International Recruitment • Medical Engagement and Recruitment • Coroner Services Oversight • Litigation Services Oversight • Oversight of Locum Management • Deputise Responsible Officer function for Medical Director
Appointment Term	Permanent

Role Description	**DMD Governance, Safety and Quality Improvement (New Post)** The Deputy Medical Director (Governance and Quality Improvement) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Clinical Leadership for Quality Improvement • Clinical Audit (National and Local inc. NCEPOD Ambassador) • Research and Development • Standards and Guideline Oversight • Infection Prevention and Control Oversight
PA Allocation	6 PA
Appointment Term	Permanent

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Role Description	**DMD Medical Education and Training (Existing Post Reconfigured)** The Deputy Medical Director (Medical Education and Training) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Undergraduate Education Leadership and Development • Postgraduate Education Leadership and Development • Physician Associate and Medical Associated Professions Governance • SAS Grade Leadership and Development
PA Allocation	4 PA (Currently funded at 2.5 PA)
Appointment Term	Permanent

13.3 Chairs of Division (9 Posts Total)

Role Description	**Chairs of Division (Operational Services)**
Number of Posts	9 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine • OPCC • Emergency & Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services
PA Allocation	PA between 2 and 4
Appointment Term	3 Years Initially

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Role Description	**Associate Medical Director – General Practice** Associate Medical Director will have professional and corporate responsibility for Primary Care.
Number of Posts	1 Post (Existing fully funded)
Areas of Responsibility	• Primary Care
PA Allocation	3 PA
Appointment Term	3 Years initially

13.4 Clinical Directors (24 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for services as directed within their divisional structures
Number of Posts	24 Posts (All existing fully funded)
Areas of Responsibility	• Assigned as per existing AMD Structure • New Clinical Director post for Research and Development • Reinstatement of Clinical Director roles (x2) for Emergency Department previously funded
PA Allocation	1PA per post (2 PA's for Research and Development post)
Appointment Term	3 Years Initially

13.5 Lead Clinicians

Role Description	**Lead Clinicians for Governance (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Governance
PA Allocation	PA cost to be agreed and funded by responsible operational directorate

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Appointment Term	2 years initially

13.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts
Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	3 Years Initially

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13.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning, • Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	3 Years Initially

13.8 Patient Safety Leads (Morbidity and Mortality Chairpersons) (19 Posts Total)

Role Description	**Patient Safety Leads (Incorporating Morbidity and Mortality Chairs) (Per speciality basis, as identified by Operational management)** Patient Safety Leads chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework

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	• Determine, support and develop appropriate patient safety inputs to the meeting • Ensure and monitor the appropriate multi-disciplinary attendance by all relevant professional groups. • Monitoring timely completion of screening templates and sign-off on NIECR • Monitoring of medical staff participation in Case Presentation • Ensure speciality meetings identify outcomes and sharing learning
Number of Posts	19 Posts (6 existing fully funded)
Areas of Responsibility	• DHH Medicine Chair (1PA) • CAH Medicine Chair (1PA) • Trustwide Surgery Chair (1PA) • Trustwide CYPS Chair (1PA) • Trustwide IMWH Chair (1PA) • Trustwide MHLD Chair (1PA) 13 Speciality Lead posts (0.5PA per post)
PA Allocation	(0.5 - 1 PA per post, depending on volume)
Appointment Term	3 Years Initially

13.9 Clinical Standards and Audit Lead (1 Post Total)

Role Description	**Clinical Standards and Audit Lead** The Clinical Standards and Audit Lead will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies. This role will include brokering actions across divisions and directorates where standards span same. This role will not remove or undermine operational DMD clinical governance responsibilities and accountabilities to their areas of service.
Number of Posts	1 Post (Previously Funded)
Areas of Responsibility	• Provide independent assessment of action taken to ensure compliance on a range of standards, guidelines and review recommendations

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	• Identify and challenge where compliance is not being achieved and lead discussions on how to improve compliance • Monitor the effectiveness of agreed action on compliance and take appropriate action to ensure clinical leadership is applied to address improved outcomes • Lead on the co-ordination of compliance discussions / actions across directorate interface areas
PA Allocation	1 PA
Appointment Term	3 Years Initially

13.10 Medical Lead for Coroners Services (1 Post Total)

Role Description	**Medical Lead for Coroners Services** The Medical Lead for Coroners Services will work with the Legal Services Manager Clinical Directors to provide professional and clinical input into the management of Coroner's cases.
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Coroner's Office and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Coroner's Office. • Provide, with the Legal Services Manager, a direct liaison and efficient communication with the Coroner's Office. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Coroner's Court which may mean attending that Court.

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PA Allocation	(3 PA, not funded)
Appointment Term	3 Years Initially

13.11 Medical Lead for Litigation Services (1 Post Total)

Role Description	**Medical Lead for Litigation Services**
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Courts and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Courts. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Court which may mean attending that Court.
PA Allocation	(1 PA, not funded)
Appointment Term	3 Years Initially

13.12 Clinical Governance Leads and Safety and Quality Improvement Leads

39. Each directorate will have the opportunity to develop Clinical Governance Lead and Safety and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

13.13 Administrative and Clerical Support Requirements

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40. To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Chair Of Division Support	Allocated within each directorate	Allocated within each directorate
Clinical Director Support	Allocated within each directorate	Allocated within each directorate
Lead Clinician Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

14. Proposal Costings

41. The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's), Infection Prevention and Control (2 PA's) and Standard and Guidelines (1 PA) were stood down and the duties merged into operational AMD roles.

42. The following costings for the revised medical leadership structure are as follows:

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
Medical Executive Posts	Deputy Medical Director – Governance , Patient Safety & Quality Improvement	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Workforce Development	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Professional and Workforce Development	4	2.5	1.5	
Operational Chair Of Division Posts	COD Surgery and Elective Care	3	0.79	2.21	
	COD ATICS	2	2	0	
	COD Medicine	4	4	0	
	COD Integrated Maternity and Women's Health	2.85	2.85	0	
	COD Children's and Young Peoples Services	3	3	0	
	COD Mental Health and Learning Disability	2	2	0	

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	COD Cancer and Clinical Services	3	3	0	
	COD Unscheduled Care &Emergency Medicine	3	3	0	
	COD Older People	3	3	0	
Corporate Services	CD Research and Development	2	2	0	*Post converted to Clinical Director Role*
	AMD Primary Care	3	3	0	
	Medical Lead for Coroner Services	1	0	1	*New Post currently unfunded*
	Medical Lead for Standards and Guidelines	1	0	1	*New Post currently unfunded*
	Medical Lead for Litigation	1	0	1	*New Post currently unfunded*
Revalidation Support	Medical Lead Corporate Appraisal & Revalidation	1	1	0	
	Medical Lead Consultant Appraisal & Revalidation	1	1	0	
	Lead SAS Doctors Appraisal and Revalidation	2	2	0	*Two Existing Funded Posts*
Patient Safety Leads	Patient Safety Leads (19 posts)	12.5	6	6.5	*Six posts Trustwide (6.5 new PA to include sub speciality M&M meetings)*
Total		**66.35**	**51.14**	**15.21**	

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
New Operational Clinical Director Posts	Clinical Director Posts Emergency Care (DHH and CAH)*	2	2	0	*Two previously funded posts*
Total		**2**	**2**	**0**	

**As of March 2020 one post has currently been recruited*

43. The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1WTE Band 4)	0 WTE	1WTE

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15. Proposed Service Enhancements and Accountabilities

15.1 Service Enhancements (Measurable Outcomes)

44. Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

45. At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline	• Responsibility for providing assurance on Trust Standard and Guideline processes

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processes and outputs	and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Learning from Experience functions	• Responsibility for the oversight and implementation of the Trust Learning from Experience function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff

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	feedback and M & M learning. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Learning from Experience processes
Strengthened support for Trust Safety & Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

15.2 Integration with Operational Management Roles

46. It is proposed the following collective forums will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

Type of Interface	Name	Composition
Corporate Interfaces & Collective Forums	Senior Leaders Forum	Trust Directors, AMDs and CDs (Bi-monthly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Weekly /

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		Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Forums	Directorate Governance Meetings	Directorate SMT Meetings (Fortnightly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

16. SMT Endorsement

47. The Medical Director asks the Senior Management Team to consider the previously set out proposal and approve its implementation

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Appendix 1 - Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trust's most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[25] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each

[25] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

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		service area
Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

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Appendix 2 - Review Process

Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

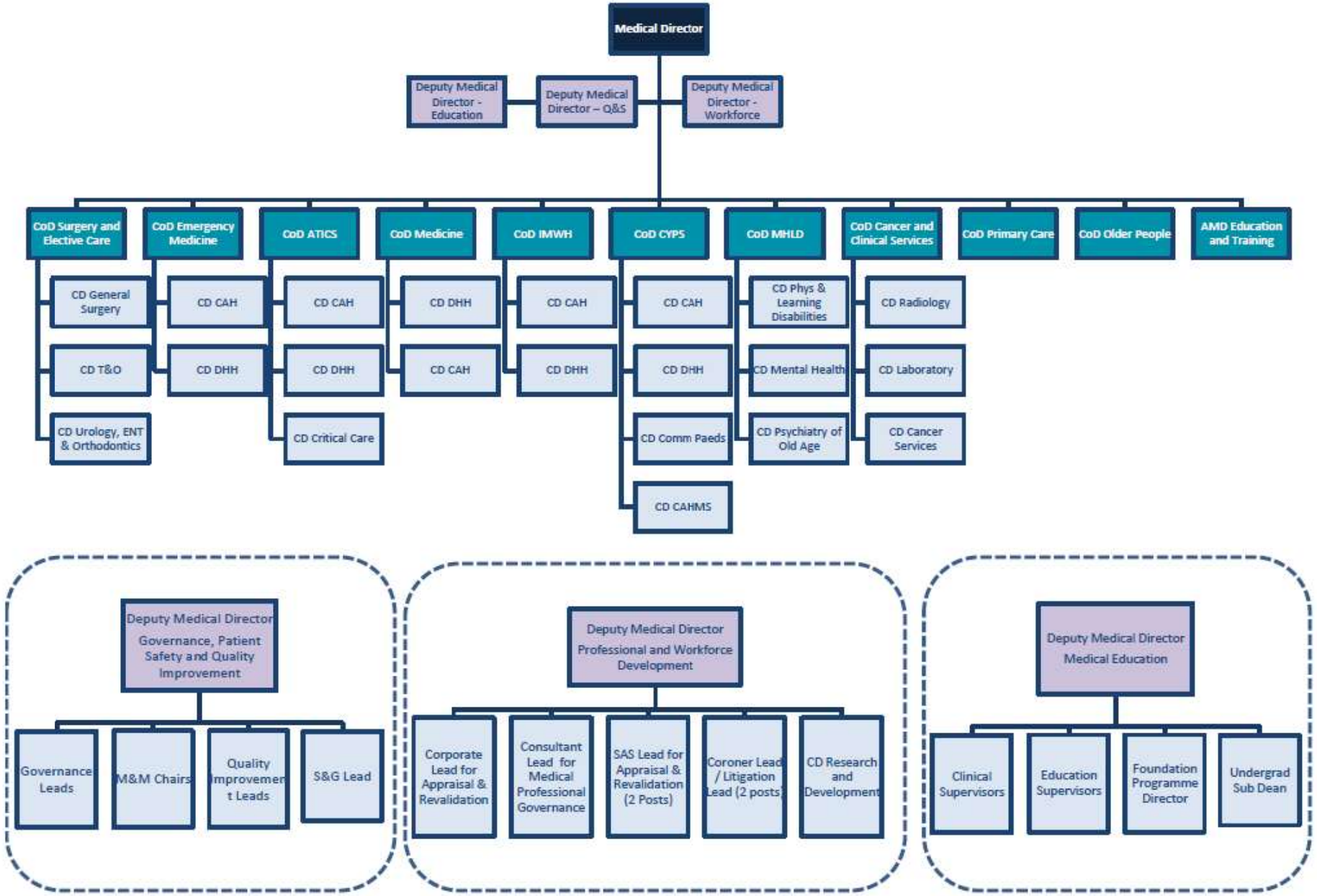
The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[26] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	2018 /2019
3	**Development of a Proposal Paper for Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	May 2019
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Quarter 2 2019

[26] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

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Appendix 3 – Proposed Revised Medical Leadership Structure



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Appendix 4 –Consultation with Trust Senior Staff

How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Clarity re role and responsibility for medical leaders vs operational managers, need clear guidance

- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A Learning from Experience MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas
- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.

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- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

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Southern Health and Social Care Trust

Quality Care - for you, with you

Medical Leadership Review

2018

V-11 - 10th September 2018

Dr Ahmed Khan

DRAFT



Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

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Section 1 – Medical Leadership Structure Review Framework

1. Background and Context

- Good medical leadership has been identified as vital in delivering high-quality healthcare[1]. There is an increasing body of published literature that links the performance of units to levels of medical leadership[2].

- To achieve strong medical leadership competence doctors are required to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which modern health and social care is delivered[3].

- The medical leadership structure within the SHSCT last underwent a review in 2011 where medical leader's functions, responsibilities and accountabilities were considered. Additional leadership roles were introduced to support medical revalidation processes, GMC responsible officer requirements and to support the development of SAS grade doctors.

- Given the length of time since this review and the significant changes in health and social care landscape it is time to review and possibly to revise, the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a highly dynamic environment.

- The structure that emerges from the review must have the appropriate processes and resources to support the effective delivery of high quality, safe, patient focussed services, and to support education and research. It must ensure appropriate ongoing scrutiny of the clinical performance of existing services, as well as new developments.

- It must facilitate timely, transparent decision making to maximise opportunities to improve existing services, and where appropriate, develop new services for patients. It

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[1] *Warren OJ, Carnall R Medical leadership: why it's important, what is required, and how we develop it Postgraduate Medical Journal 2011;87:27-32.*
[2] *Clark J. Enhancing medical engagement in leadership. InView 2006;10:14e15.*
[3] *Darzi A. A time for revolutions – the role of clinicians in health care reform. N Engl J Med. 2009;361(6):e8.*

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must encourage all clinicians contribute to the development of the Trust strategic planning and then take responsibility for contributing to its delivery.

2. Strategic Drivers

- The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental[4].

- The leadership task is to ensure direction, alignment and commitment within teams and organisations Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work.

- Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[5].

2.1– HSC Collective Leadership Strategy

- Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

2.2United Kingdom Regional Workforce Strategy Policy Direction

- All NHS UK regional Departments of Heath have endorsed leadership models that suggest clinicians need to become more actively involved in the planning, delivery and transformation of health and social care services[6,7,8,9.]

[4] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*
[5] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

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- Current NHS Workforce Strategies are based on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

- Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

  - ***Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services***
    "*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

  - ***Department of Health England, Next Stage Review: High Quality Care for All***
    "Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

  - ***NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership***
    "Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

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[6] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*
[7] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*
[8] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*
[9] *National Leadership and Innovation Agency for Healthcare Wales*
1 HSC-*Collective Leadership strategy*

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- ***National Leadership and Innovation Agency for Healthcare Wales***
  "Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. Why Invest In Medical Leadership

- Clinicians across Health and Social Care are often be asked to take on leadership roles, with responsibility for staff objectives, appraisal, and performance management, as well as all other resource management issues, without supports to help them make the necessary transformation into these roles.[10].

- Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

3.1 The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[11]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[12]

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[10] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[11] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[12] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*

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- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[13]
- A study in the Harvard Business Review (*Bassi and McMurrer*) provides a strong link between leadership skills and organisational performance[14]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[15]

4. Review of Best Practice Literature

4.1 NHS Medical Leadership Competency Framework (MLCF)

- The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

- The MLCF describes leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice, Tomorrow's Doctors and also Management for Doctors.

- While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services.

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[13] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*
[14] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[15] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

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- Doctors also have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. The development of leadership competence needs to be an integral part of a doctor's training and learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

- The Medical Leadership Competency Framework (MLCF) is built on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

4.2 Clinical Leadership Competency Framework (CLCF)

- The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

- The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

- Clinicians have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

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4.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

- The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring: the team has articulated a clear and inspiring vision of the team's work; there is clarity about the team's membership; team members agree five or six clear, challenging, measureable team objectives; there is strong commitment to collaborative cross-team and cross-boundary working.

- The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

- Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

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5. Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trusts most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[16] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each service area

[16] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

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Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

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6- Review Process timeline

6.1- Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

6.2- The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[17] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	30th July 2018
3	**Development of a Proposal Paper for SMT Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	30th October 2018
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Jan 2019

[17] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

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7. Current Trust Medical Leadership Structure

7.1- Medical Leadership Structure (since 2011)

- The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

- The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the consolidation and discontinuation of two AMD positions:

    - **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
    - **AMD Infection Prevention and Control – *Post not retained (2015)***

7.2- The current Southern Trust Medical Leadership Structure is outlined below:

Medical Leadership Structure Today (June 2018)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care (Aligned to OPPC)
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *4 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*

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AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair & Sub-speciality chairs
CAH Medicine Chair* & Sub-speciality chairs
Trust wide Surgery Chair* & Sub-speciality chairs
Trust wide CYPS Chair
Trust wide IMWH Chair
Trust wide MHLD Chair

* *Medicine and Surgical Specialities are supported*

8. The Case for Change

- Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

8.1 Supporting and Influencing Service Planning

- Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.

- Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes.

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Doctors are uniquely positioned to understand the potential impact of policy or funding changes[18].

8.2 Providing a Link from Ward to Board

- Medical leaders understand the complexity of modern health care services and understand both how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[19].

8.3 Performance of Frontline Teams

- There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

[18] *Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.*
[19] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

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9 Consultation with Trust Medical Leadership

- As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model. A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix.
- A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

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- The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

- Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

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10. Consultation with Trust Directors

10.1 Trust Directors were asked to give their views and opinions on current medical leadership structure. A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role.

10.2 A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

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Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

10.3 The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

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11. Comparison with Analogous Organisations

11.1 - Northern Ireland Regional Trusts

- The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust
• Medical Director • Deputy Medical Director • AMDs • Clinical Director Structure*	• Medical Director • Deputy Medical directors • AMDs • Clinical Director Structure*
Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director • Clinical Director Structure* • Lead Clinicians	• Medical Director • Deputy Medical Directors x3 (5PA each post) • Divisional Director leads • Clinical Director Structure* • Lead Clinicians**

** Lead clinicians are formal roles within the medical leadership structure

11.2 NHS United Kingdom Acute Trust Models

11 The following comparison is of two NHS UK Trusts who have published their medical leadership structures, it is important to note that terminology of medical leadership role titles is often unstandardized and responsibilities can vary widely.

Mid Cheshire NHS Foundation Trust	Warrington and Halton Hospitals
• Medical Director • 1 DMD • Clinical Director Structure* • 1 Patient Safety lead • 1 Clinical effectiveness lead •	• 1 MD • 1DMD (8 PAs) • Clinical Director Structure* • Lead Clinicians**

*Clinical Directors are equivalent of SHSCT AMD roles

**Lead clinicians are formal roles within the medical leadership structure

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Section 2 – Proposed Medical Leadership Structure

12. Medical Leadership Development and Competence

12.1 The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's) and Infection Prevention and Control (2 PA's) were stood down and the duties merged into operational AMD roles.

12.2 To further integrate the role of Associate Medical Directors and Clinical Directors with the Medical Director it is proposed that one third of the cost of operational AMD and CD PA role cost is funded from the Medical Directors budget (the remaining two-thirds met from existing operational directorate funds). The revised PA funding allocation will allow a portion of medical leadership responsibilities to be aligned to the medical director formally.

12.3 A supplementary paper titled ***"Medical Management and Leadership Development Program"*** will follow.

13. Medical Leadership Fixed Term Appointments

13.1 This paper proposes that all senior medical leadership positions commencing from January 2019 are fixed-term appointments (details found in subdivision 13 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

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14. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

14.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services, support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	10PA
Areas of Responsibility	• Medical Professional Governance including RO duties, • Clinical and Social Care Governance, • Medical Workforce Development, • Medical Education & Training • Audit & Research with Linked to QI,

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	• Infection Prevention and Control • Emergency Planning
Appointment Term	Permanent Post

14.2 Deputy Medical Directors (2 part time Posts Total)

Role Description	**DMD – Workforce Development (New part time post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	5 PA (To be funded from proposed new MD budget)
Areas of Responsibility	• Medical Appraisal & Revalidation • Job Planning • Medical Professional Governance • Litigation Oversight
Appointment Term	5 years Initially – with 1 year extension if required

Role Description	**DMD- Safety and Quality (New part time post)** The Deputy Medical Director (Safety and Qualit) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality Lead • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Quality Improvement

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	• Clinical Audit
PA Allocation	5 PA (To be funded from proposed new MD budget)
Appointment Term	5 years Initially with 1 year extension if required

14.3- Associate Medical Directors (10 Posts Total)

Role Description	**Associate Medical Directors (Operational Services)**
Number of Posts	8 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine and Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services • A/E (Currently included in Medicine & unscheduled care)
PA Allocation	3 PA per post (1 PA funded from proposed new MD budget, 2 PA's from Operational Budget)
Appointment Term	4 Years Initially with 1 Year extension if required

Role Description	**Associate Medical Directors (Corporate Services)** Associate Medical Directors with professional and corporate responsibility for Medical Education and Research and Development.
Number of Posts	2 Posts (All existing fully funded)
Areas of Responsibility	• Medical Education & Training • Research and Development
PA Allocation	3 PA per post (funded from MD budget)
Appointment Term	4 Years Initially with 1 Year extension if required

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14.4 Clinical Directors (22 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for
Number of Posts	22 Posts (All existing funded for 1PA)
Areas of Responsibility	Assigned as per existing AMD Structure
PA Allocation	1.5 PA per post (0.5 PA funded from proposed new MD budget, 1 PA from Operational Budget)
Appointment Term	3 Years Initially with 1 Year extension if required

14.5 Lead Clinicians

Role Description	**Lead Clinicians (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Assigned as identified by operational directorates
PA Allocation	PA cost to be agreed and funded by responsible operational directorate (proposed 0.25 -0.5PA)
Appointment Term	2 Years Initially with 1 Year extension if required

14.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts

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Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Deputise for Responsible Officer for signing-off revalidation paperwork • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning,

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	• Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.8 Morbidity and Mortality Chairpersons

Role Description	**Morbidity and Mortality Chairs (Per speciality basis, as identified by Operational management)** A separate paper has been developed for Morbidity and mortality. M&M chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework • Determine, support and develop appropriate patient safety inputs to the meeting • Monitor the appropriate attendance by all relevant disciplines and professional groups • Monitoring timely completion of screening templates • Monitoring of medical staff participation in Case Presentation
Number of Posts	6 Posts (existing funded) + 4 subspecialty
Areas of Responsibility	• DHH Medicine Chair • CAH Medicine Chair • Trustwide Surgery Chair

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	• Trustwide CYPS Chair • Trustwide IMWH Chair • Trustwide MHLD Chair • Sub speciality Chairs
PA Allocation	1-1.5 PA per post (depend on workload (1PA currently funded)
Appointment Term	3 Years Initially

14.9 Clinical Governance Leads and Quality Improvement Leads

- Each directorate will have the opportunity to develop Clinical Governance Lead and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

14.10 Administrative and Clerical Support Requirements

- To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Role	Time Allocation	Supporting Band
Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Associate Medical Director Support	6 hours per AMD per week (10 posts)	1.5 WTE Band 3
Clinical Director Support	1.5 hour per CD per week (22 posts)	1.5 WTE Band 3
Lead Clinician & M&M leads Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

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15. Proposal Costings

15.1 To support this arrangement a budget for medical leadership that is the responsibility of the medical director will be required to be established in Medical Directorate.

15.2 The proposed costing for new model would be based on:

	Proposed New Medical Director Budget (Allocation Per Post)	Operational Directorate Budget (Allocation Per Post)
Associate Medical Director (3 PA) Per Post	1 PA	2 PA
Clinical Director (1.5 PA) Per Post	0.5 PA	1 PA

15.3 The following costings for the revised medical leadership structure are as follows.

	Currently Funded	New / Additional Funding Required
Medical Director	10PA	0PA
Deputy Medical Director – part time (Workforce Development)	New Post	5PA
Deputy Medical Director – part time (Safety and Quality)	New Post	5PA
Associate Medical Directors (Operational)	24PA	0PA
Associate Medical Directors (Corporate)	8 PA	0PA
Appraisal and Revalidation Corporate and Consultant Leads	2PA	0PA
Appraisal and Revalidation SAS Lead	1PA	1PA
Clinical Directors	22PA	11PA
M&M Chairs & subspecialty chairs	6PA	3PA*

**3 PA's for M&M chairs are to formalise support for sub speciality M&M meetings in Medicine and Surgery specialities*

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2 The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1 WTE Band 4)	0 WTE	1 WTE
Associate Medical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE
Clinical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE

**Please note this is rough estimate only*

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16. Proposed Service Enhancements and Accountabilities

16.1 Service Enhancements (Measurable Outcomes)

- Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

- At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline processes and outputs	• Responsibility for providing assurance on Trust Standard and Guideline processes and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust

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	• Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Lessons Learned functions	• Responsibility for the oversight and implementation of the Trust Lessons Learned function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff feedback. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Lessons Learned processes
Strengthened support for Trust Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety

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	improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

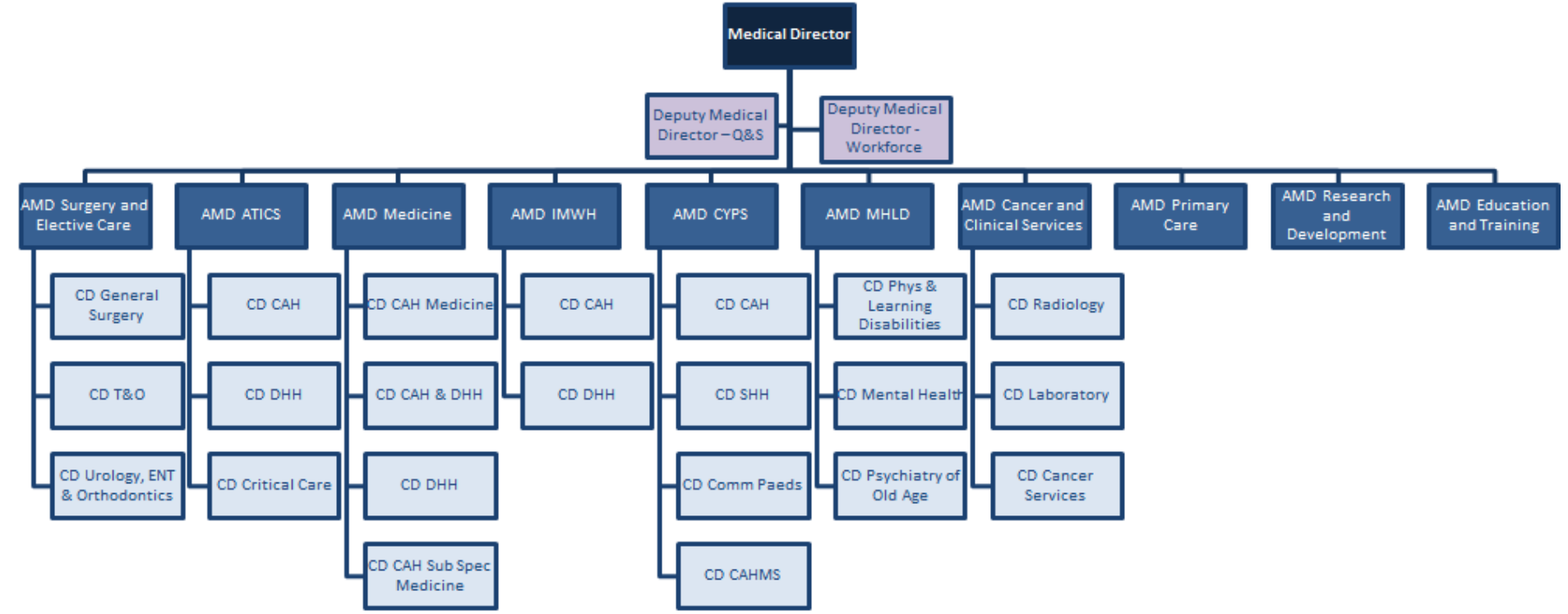
16.2 Integration with Operational Management Roles

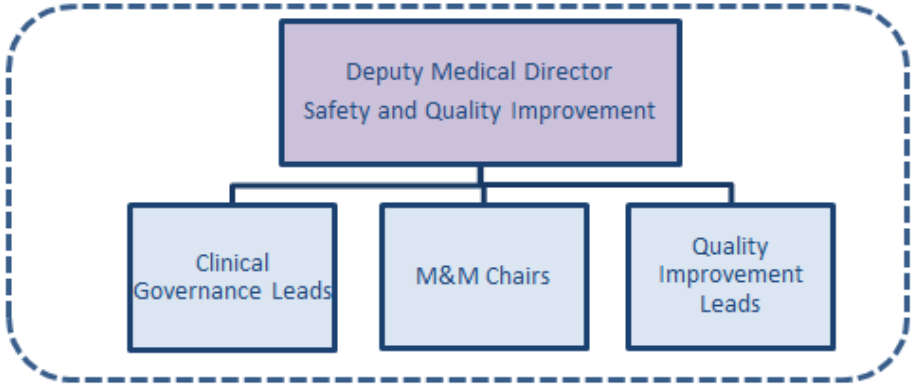
- It is proposed the following initial formal interfaces will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

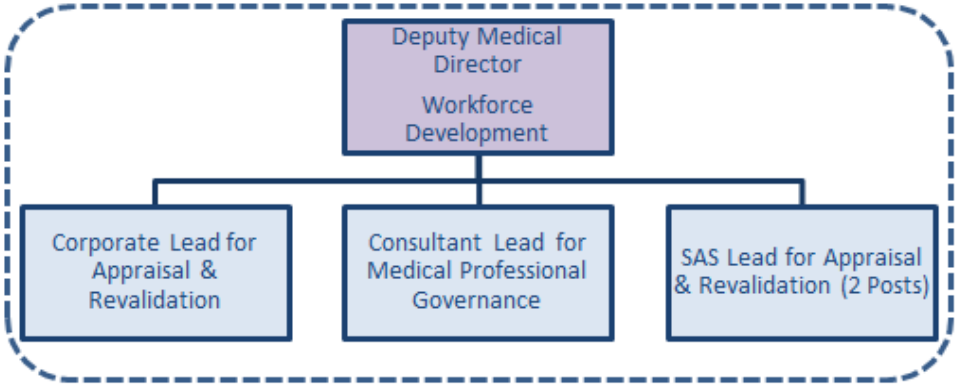
Type of Interface	Name	Composition
Corporate Interfaces	Senior Leaders Forum	Trust Directors, AMDs and CDs (Quarterly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Interfaces	Directorate Governance Meetings	Directorate SMT Meetings (Monthly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

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Appendix 1 – Proposed Revised Medical Leadership Structure







Appendix 2 – Consultation with Trust Medical Leadership

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Appendix 3 –Consultation with Trust Directors

1) How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

2) How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Also covered by my suggestion for Question 2 point 2

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- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Calrity re role and responsibility for medical leaders vs operational managers, need clear guidance
- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

3) Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD (now off) took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A lessons learned MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas

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- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.
- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

4) Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

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big and unwieldily, and over number of acute hospital sites with Surgery, Medicine, ED, all in there in the mix. So communication about all those issues that were going on was very difficult.

15:43

It probably didn't help that the Director of Acute Services was located in one of the acute hospitals, we were physically in a different place. That made informal interactions more challenging. I think there was a lack of medical professional representation at 15:43
Board level. I mean there was me, and that was it. I think to be running an acute hospital of that size with one doctor at that sort of level is probably not enough. There was very little back-up for the Medical Director in terms of ability to delegate issues to 15:43
other team members because there really weren't any.

216 Q. That's evident from the structure as it was. It's too big a job for it to be for one person really, in your view, and I would agree with that. There have been some examples of that. 15:44

You formed a view on this quite early on and you set out to develop the senior medical leadership management capability, although I think you would agree nobody quite had enough time devoted in some areas? 15:44

A. Oh, yes.

217 Q. And you put some training in. What did you see your personal role as in terms of mentoring these people? Were you able to give some thought to how you could

money, it is about seeing how they are valued and their views expressed.

I do think there was a bit of a culture within the Southern Trust, as in the health service in Northern Ireland generally of keeping doctors out of positions where they could actually take decisions. That's my personal view. I think that's been unhelpful and we need to get a more mature view where they can feel engaged. I think that is beginning to happen. I know there have been a lot of changes within Southern after I left, as well. 15:51 15:51

The other extreme would be something like the States where some people train jointly in medical leadership and management as in medicine right from the outset as a career path. We're not quite there yet, but there are some things we are doing around the adept fellows, which have been very encouraging and rewarding in giving junior doctors experience of management and leadership roles at an early stage. 15:51 15:51

226 Q. There's a lot to do. I would agree.

The route into that will be, I think, through the Medical Directors and medical professionals responsibility for clinical risk, Patient Safety and quality. I think that's the toughest part of the Board position because there's so much to that. There are a lot of safety and quality issues that have emerged as 15:51

challenges, it probably falls within the four areas of culture, governance - and within that I mean clinical and social care governance and corporate governance - how we've used data, and then the quality and safety within the organisation. And as I've mentioned in some of the previous submissions, we have brought on board an External Reference Group to help us with the thinking in relation to all of that, and I think, you know, in terms of those four main domains, then within all of that, if we apply, you know, a model for improvement such as, you know, the Vincent model, which looks at, you know, were we safe yesterday, are we safe today, will we be safe tomorrow, are our systems and processes sensitive enough to operations so that we understand that if things are going askew that we have the governance arrangements in there to pick that up at an early stage? And also the fifth leg of all of that, which is, then how do we drive improvement based on all of that? If I use that as the framework for thinking of this, this is my easiest way into it. 14:09 14:09 14:09 14:10

So in relation to where we were in relation to corporate governance. As you have pointed out, the June Champion review was undertaken across the summer of 2019 and, again, that was in response to my concerns about the lack of framework and structure around some of the patient safety and quality issues that we were dealing with. As you know, there were 48 recommendations in that report. We have filled out on 14:10

Directorates. It is about trying to say how are we doing. You will be familiar with stroke, there is 10 indicators in the national stroke audit which most places use as a sort of 'how are we doing.' It is a mixture of performance, practical things that make a better service and so on, and that generally would come to committees regularly as would, for example, overall compliance with cancer standards, which are part of performance really, because they are basic, 'have you done this, have you done that', they are not individual quality of care. So what discussions has the Board had about what the Board would like to see about safety throughout the Trust and has that discussion happened in terms of what do we need to know, how do we need to know more, how has that been informed by your Medical and Nursing Directors and others? 12:29 12:29 12:29

A. Yeah. I mean, I think that's a conversation that Dr. O'Kane has started with us. I would have a concern that standards and guidelines, that part of governance is under resourced, that has come to the Board. 12:30

133 Q. I mean, that's a huge piece of work. But even before fixing all of that, there is an indicator in almost every service that relates to a national audit, there is at least one, probably four or five indicators that can be tracked. Then you don't need people to come and tell you there is a problem because you know there is a problem, you can see it changing over time. If you are now waiting three days to have your fracture, like a femur operated on and you were waiting 12 hours, you 12:30

Boards operate that has this in built, you just sit there and wait there until you are questioned, so that curiosity wasn't coming through and then were the questions the right questions and were we focussing our attention on the right areas. 11:32

75 Q. Now, we have heard from quite a number of people, and I think you have alluded to this yourself, that there was a tendency for people to look at operational matters, professional matters and senior oversight as separate things and that's not always helpful. This 11:33 crystallised in some way in some of the Serious Adverse Incidents where there was a tendency to say 'well we have given that to the Directorate and they are going to deal with it all in terms of the action plans', and clearly they were not able to deal with the action 11:33 plans and there was a failure of oversight, if you like, not through intent but through volume and the way it was all set up. Now you have described quite a lot of improvements, including lessons learned and more focus on SAIs. 11:33

First of all, with the lessons learned, do the right people go to those meetings now? Because the previous attendance list was quite sparse, so do you think that is really working for you or is there a way to go? And 11:33 then the learning for the Board, have you got to the stage of presenting thematic learning to the full Board in terms of 'this has been the learning this year, these are the things we have changed', has it got to

that stage, do you think?

A. I'll take the last one first. We are not there yet, we are not there yet. The outworkings of the Champion review, the operation of governance layer that has been put in place, we are only starting there in terms of that feeding through. My aspiration is it will do just that, it will do just that. But I am hoping over the course of this incoming year we will see that bed in, the committee bedding it in and the teams then certainly being able to feed up what needs to be the focus of attention for the committee and the areas of concern and risk. I do get a sense, though, listening to our Directors, because they are a few months ahead of us in terms of their delivery of the operation, that they are being exposed to more than they have ever been exposed and they are unpacking things more than they unpacked before. I am getting a sense that there is a real visibility for them across a broader piece and they are joining dots. 11:34 11:34 11:35

76 Q. Because it is quite a difficult task, isn't it? You get lots and lots of action plans for lots of things, it is not that easy to keep it all in track. But if people recognise the need and have a plan to do so, that is probably the first step, and you think that's kind of where you are getting to? 11:35

A. Yeah, and it needs to be followed up. It is not a case of, okay, well, that's done, we'll leave that there, we don't need to worry about it, we need to follow it up, is it complete, all right? And coming to your first

21 What was the Board's attitude to risk and risk management? What processes were in place to assist the Board in identifying and responding to risks related to clinical concerns and patient safety?

21.1 The Governance Committee has been the committee that receives and discusses the Corporate Risk Register at its quarterly meetings. During my tenure as Chair of the Governance Committee, 'deep dives' on Corporate Risks were instigated from 2019. These allow for risks and mitigations to be further explored to ensure that the right measures are in place in relation to a risk. Senior Management Team review the Risk Register on a regular basis and update it accordingly. Each Directorate carries its own Risk Register and, where risks can no longer be managed at Directorate level, they are escalated to the Senior Management Team.

21.2 The Board receives the Chair's Report from the Governance Committee and, yearly, receives the Corporate Risk Register in full.

21.3 The Chief Executive and Accounting Officer is the Accountable Director and holder of the Risk Register.

21.4 The Risk Register should be a fluid document which should (and does) change as risks are mitigated and removed and as new risks come into existence.

21.5 The Trust has not in my time had a 'Risk Appetite Statement'. However, work has begun on this, with a dedicated workshop in November 2021 externally facilitated by Dr John Bullivant FRCPE. This has been further developed through a Trust Board workshops on the 18th May 2023 and 18th September 2023The current work on establishing an appropriate level of risk appetite will further support the Board.

21.6 Although there is, as yet, no Risk Appetite Statement, my experience on the Board has been that it takes the question of risk generally very seriously and that it has no appetite for any risks that relate to clinical concerns and patient safety.

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion

PEOPLE & CULTURE GROUP
TERMS OF REFERENCE

VERSION	1.0
ASSURANCE	**SECOND LINE ASSURANCE**
PURPOSE	The People & Culture Steering Group is part of the second line of assurance within the revised Integrated Governance and Assurance Framework. It will support the delivery of the Trust's Vision, Corporate Objectives and Priorities, identifying the gaps in controls and the constraints that prevent their achievement. **Assurance** The purpose of the People & Culture Steering Group (the Group) is to provide support to the Trust Strategy & Transformation Committee by obtaining assurance that: • the Trust has plans with ambitious but realistic goals and targets relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives. • the plans to achieve those goals and targets are being implemented. • our people are reporting that our plans are making a difference to their working lives. For example, they will initially oversee and support the implementation of the Trust's People Framework 2022-2025 to enable the Trust to achieve our ambition.  **Alerting** The Group will alert the Trust Strategy & Transformation Committee where assurance cannot be given or further work or consideration is required by the Senior Leadership Team or at Committee Level. **Advising** The Group will advise the Strategy & Transformation Committee on matters within the scope of the Group's Terms of Reference. **Accountability** The Group is accountable to the Trust Strategy & Transformation Committee who in turn is accountable to the Trust Board.
MEMBERSHIP	Membership will initially consist of the Director of HROD, Deputy Director of HROD, 3 Executive Directors and Assistant Directors for the other directorates not represented. **Chair: Director of Human Resources & Organisational Development**

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

started to strengthen the governance from the June Champion report in terms of putting in those reports into the Clinical and Social Governance part of the Governance Committee.

75 Q. Is that to imply that the deficit of information sharing with the Board, which you have already alluded to in response to my questions, is not now the picture, it shouldn't have been the picture at the time but the position has now changed? 11:13

A. I think there's been a considerable cultural shift in the Board. We're working together much more as a collaborative Board. It doesn't mean that you don't ask hard questions, you don't scrutinise. I mean, some of the meetings are quite robust in terms of the many challenges and pressures that come up in the Trust Board. But I think that the culture has really encouraged I think particularly through the current Chair and the Chief Executive, encouraged an environment where staff feel much more psychologically safe, where they can come to us and tell us if they have concerns, where there are risks and together we look at how we can minimise those and put in mitigations. 11:13 11:14 11:14

76 Q. Just looking at minute in front of us, we see that Ms. Donaghy has picked up on a point which I was addressing yesterday, which is the Early Alert. She is asking when was this Early Alert submitted, that seems to indicate a view that perhaps there was a degree of unhappiness on the part of NEDs that you had been kept 11:14

111 Q. What would you put that down to? Would you say that that's improved leadership, would you say it's improved culture as a result perhaps of learning from urology or what is it?

A. Yeah, I think there is a number of factors. I think certainly the current Chair and the Chief Executive are very mindful that our priority is patient safety. Alongside that, particularly Dr. O'Kane would emphasise psychological safety. So staff are encouraged to come to us with any risks, any concerns as quickly as possible. So there has been a big cultural change there in terms of the swiftness of issues being raised and the information being given to us very quickly and comprehensively. 12:15 12:15

MR. WOLFE: Okay. Thank you for answering my questions, I apprehend that the Panel might have some further questions for you. Thank you. 12:16

CHAIR: Thank you, Mr. Wolfe. I am afraid we can't let you go just yet, Ms. Leeson, Mr. Hanbury has a couple of questions. 12:16

THE WITNESS WAS THEN QUESTIONED BY MR. HANBURY, AS FOLLOWS:

MR. HANBURY: Just a couple of questions for you. Thank you very much for your information statements. 12:16

112 Q. You managed to, as a Board, make a difference when the issues of the cardiology department and stroke problems came through, obviously on the medical as opposed to

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

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

49.1

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

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

really, and seeking out help, seeking out support from a corporate perspective, as opposed to trying to keep it from within because they don't really want anyone to look at that.

159 Q. Finally then, you described the improvements in MHPS reporting. I think, you, yourself, suggest that's the tip of the iceberg, really, in terms of understanding all the informal issues and all the improvements you need to make. So I think from what you said that's been helpful in terms of increasing the discussion engagement at Governance Committee and, hopefully, at the Board in due course. 13:09 13:10

Have you seen any other improved engagement that fits along with the Just Culture kind of idea at Board level as a result of the work that you have had to do for this Inquiry and the work that others have had to do. Have you seen anything else filtering through that would be helpful for us to know about? 13:10

A. I think from a Board perspective, I mean there's very much that openness. There's the openness to bring problems at a much earlier stage and I think that is very much welcomed. I mean inevitably across different services, even Acute Services, there is issues and it is very much a full disclosure, there's an openness, there's engagement at an early stage to say "this is what we're dealing with". The discussion is had. There's the challenge there. There's the follow-up there. I suppose I'm seeing more of that. 13:10 13:11



with each consultant. *Relevant document located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101206 Uro Issues re Long Wait Pts*

28.3 Specific meetings not held on a regular basis included the following:

a. 1 December 2009 meetings re range of governance issues chaired by the Chief Executive, with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services. The range of issues on the agenda included:
    i Demand and capacity and the need to optimise the use of clinical sessions;
    ii Quality and safety - Medical Director to discuss with Mr Fordham seeking an urgent professional opinion on:
        A The appropriateness and safety of the current practice of IV antibiotics;
        B Triage of referrals and 1 consultant refusing to meet the current standard of triaging within 72 hours;
        C Red flag requirements and 1 consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately;
        D Chronological management of theatre lists for theatre with 1 consultant keeping patients' details locked in the desk.
    iii Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

b. 7 December follow up meeting with Mr Young, Consultant Urologist after 1 December meeting. Key points of discussion are set out. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service*

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

sub-committee unless expressly authorised by the Trust Board.

4.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Minister for Health. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.6 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Minister for Health and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Minister for Health.

4.7 Committees established by the Trust Board

Trust Board sub-committees will be held by virtual means for the foreseeable future. The committees, sub-committees, and joint-committees established by the Board are:

4.7.1 Audit Committee

In accordance with current Cabinet Office Guidance and in line with the Department of Finance Audit and Risk Assurance Committee Handbook NI (April 2018), Codes of Conduct and Accountability (2012), an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective view of internal control by a review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the HSC. The Terms of Reference will be

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

reviewed annually by the Committee and approved by the Trust Board.

The Committee will be comprised exclusively of non-executive directors, with a minimum of three, of which one must have significant, recent and relevant financial experience. A quorum shall be two members. None of these members should be the Chair or members of the Remuneration Committee. The Committee will meet on at least four occasions per year.

A Department of Health representative will attend at least one Audit Committee meeting per year as an observer and will not participate in any Audit Committee discussion.

The Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement. Any exception issues should be reported to the Department.

4.7.2 Remuneration and Terms of Service Committee

In line with the requirements of the Codes of Conduct and Accountability, a Remuneration and Terms of Service Committee will be established and constituted.

The Committee will be comprised exclusively of the Chair and at least two Non-Executive Directors.

The primary responsibility of the Remuneration and Terms of Service Committee is to make recommendations to the Board on all aspects of remuneration and terms and conditions of employment for the Chief Executive and other Senior Executives. The purpose of the Committee will be set out in a formal terms of reference that will be available to the public on request. Meetings should be held as a minimum, once per year, to review remuneration matters or deal with specific matters. Further meetings may be arranged at the discretion of the Chair, as necessary.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

4.7.3 Endowment and Gift Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust Endowment and Gift Funds Committee to administer those funds in accordance with any statutory or other legal requirements.

The Committee will be comprised three Non-Executive Directors, the Director of Acute Services and the Director with responsibility for Estates Services. The Director of Finance will be in attendance. A quorum shall be 3 members.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and the Standing Financial Instructions.

4.7.4 Governance Committee

In line with its responsibility for integrated governance, the Board will establish a Governance Committee to oversee the effective development and implementation of integrated governance arrangements and ensure compliance with statutory or other legal requirements.

Within the Audit and Risk Assurance Committee Handbook (2018), there is a strong emphasis on risk and assurance for the Trust and this is delivered by both the Governance and Audit Committees.

The Governance Committee will support the Board in all aspects of corporate and clinical and social care governance with financial governance the responsibility of the Audit Committee.

The Committee will be comprised exclusively of non-executive directors, with a minimum of three. A quorum shall be two. The Committee will meet on at least four occasions per year.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

4.7.5 Patient and Client Experience Committee

The Trust Board will establish a Patient and Client Experience Committee to provide assurance that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement. The Committee will also be responsible for identifying opportunities for development to deliver ongoing improvements in those areas impacting on the user experience of care.

The Committee will be comprised of non-executive directors, with a minimum of three and up to four Personal and Public (PPI) Panel members. A quorum shall be three members, two of which must be non executive directors. The Committee will meet on at least four occasions per year.

4.7.6 Performance Committee

The Trust Board will establish a Performance Committee to assist the Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.

The Committee will be comprised exclusively of non-executive directors, with a minimum of four. A quorum shall be two. The Committee will meet on at least four occasions per year.

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ORGANISATIONAL CHART

October 2021

Southern Health and Social Care Trust

Quality Care - for you, with you

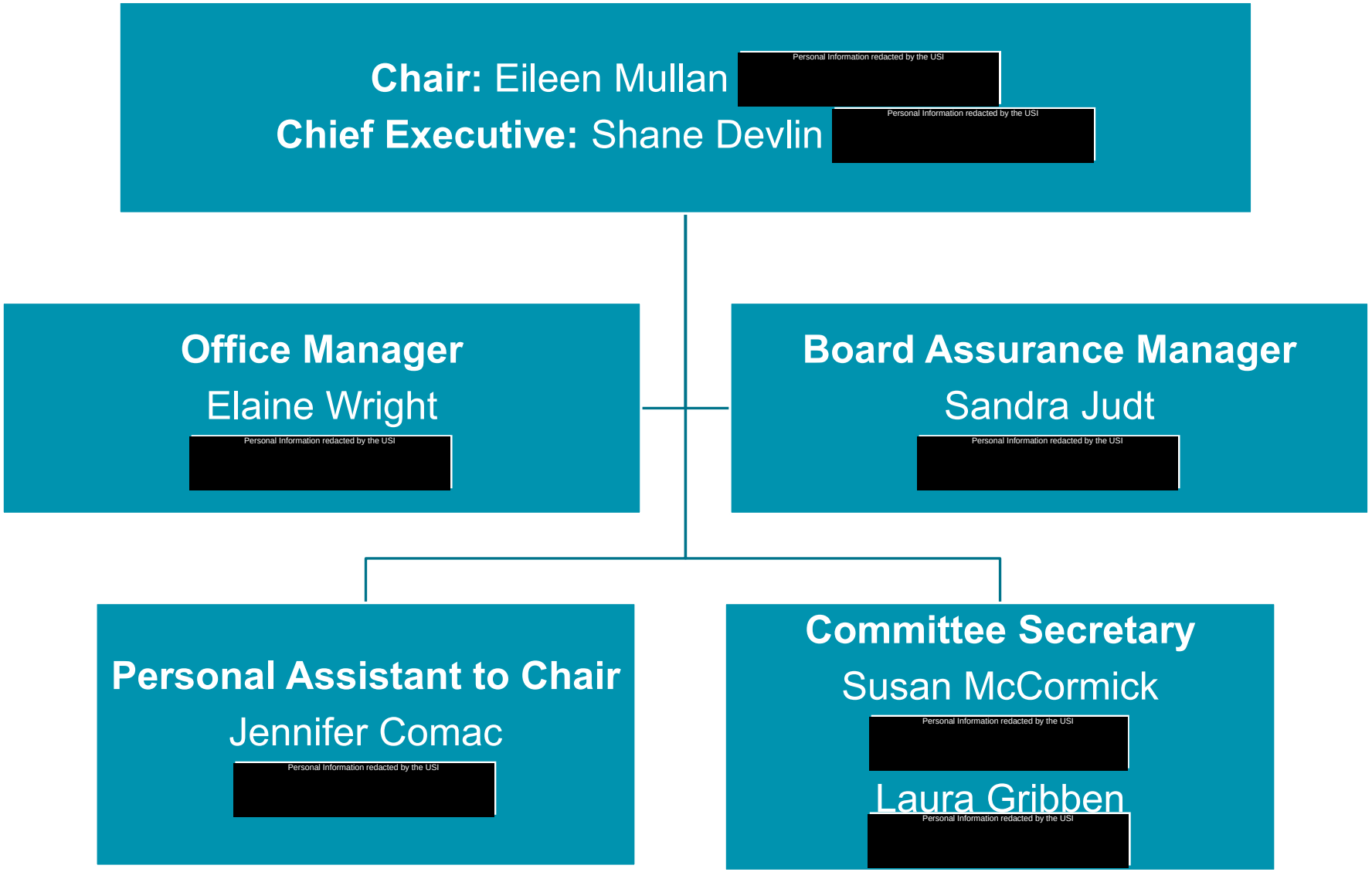
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Office of the Chair and Chief Executive

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Chair and Chief Executive's Office SHSCT Headquarters

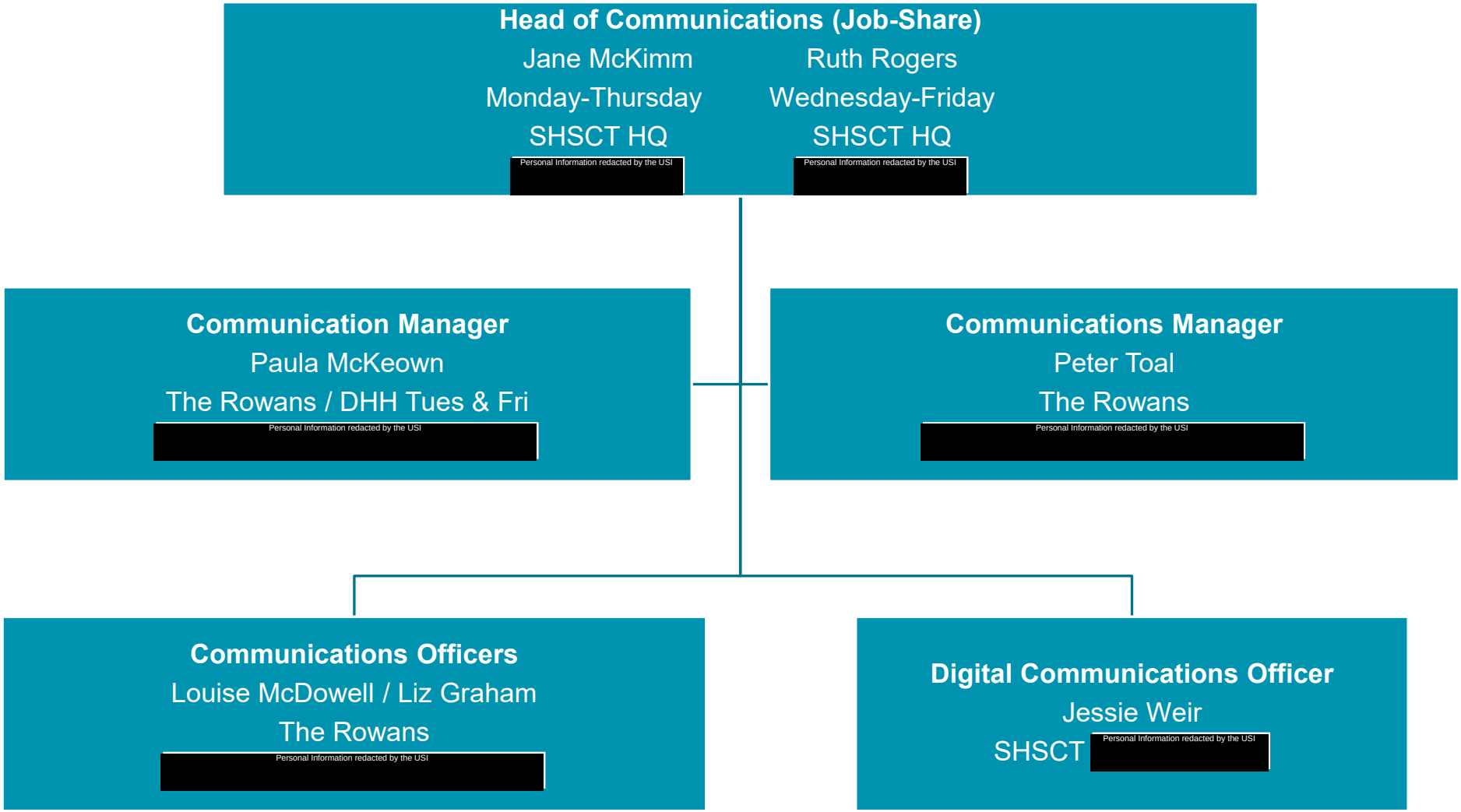
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Communications Team

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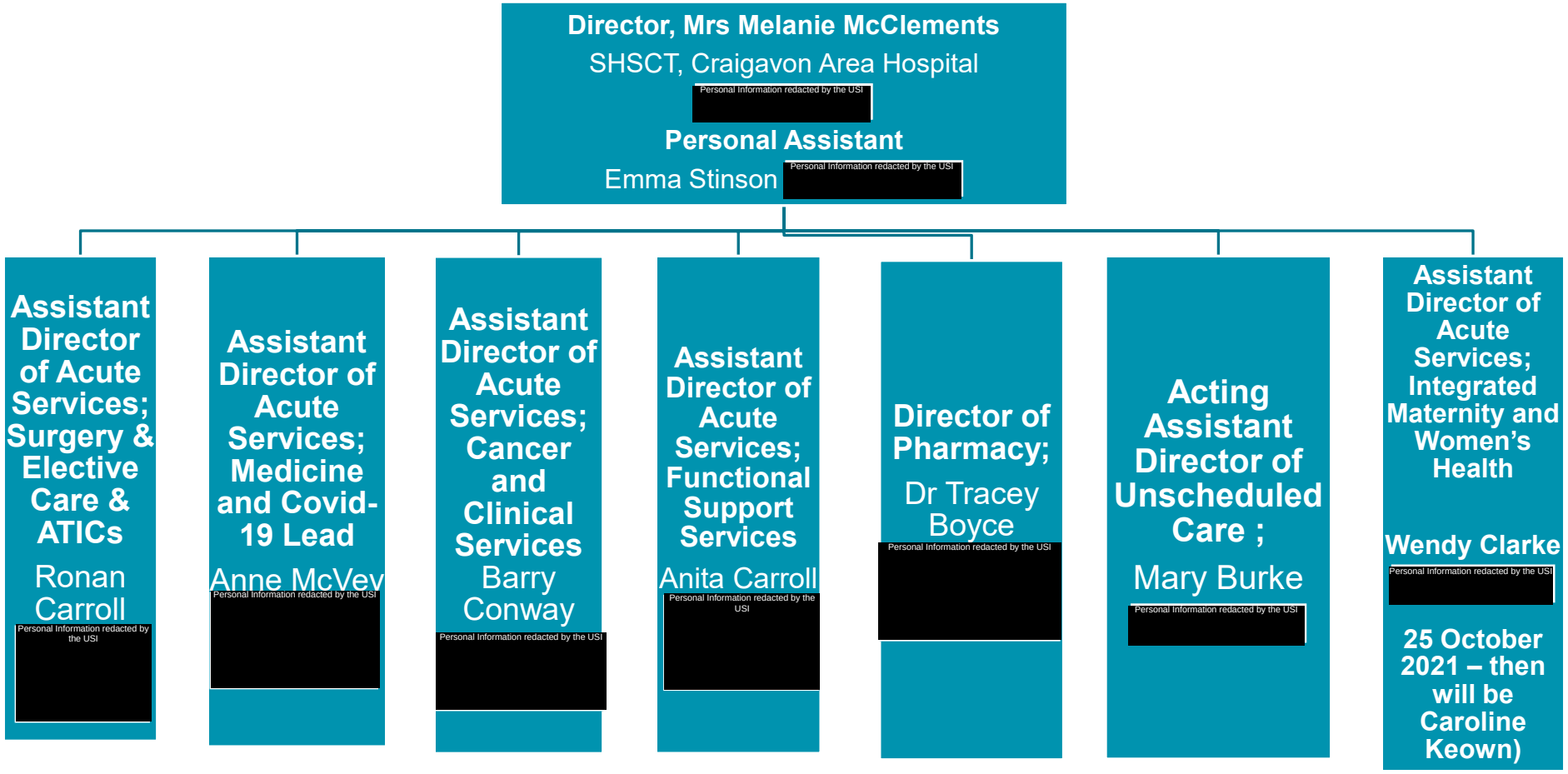
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Directorate of Acute Services

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Directorate of Acute Services

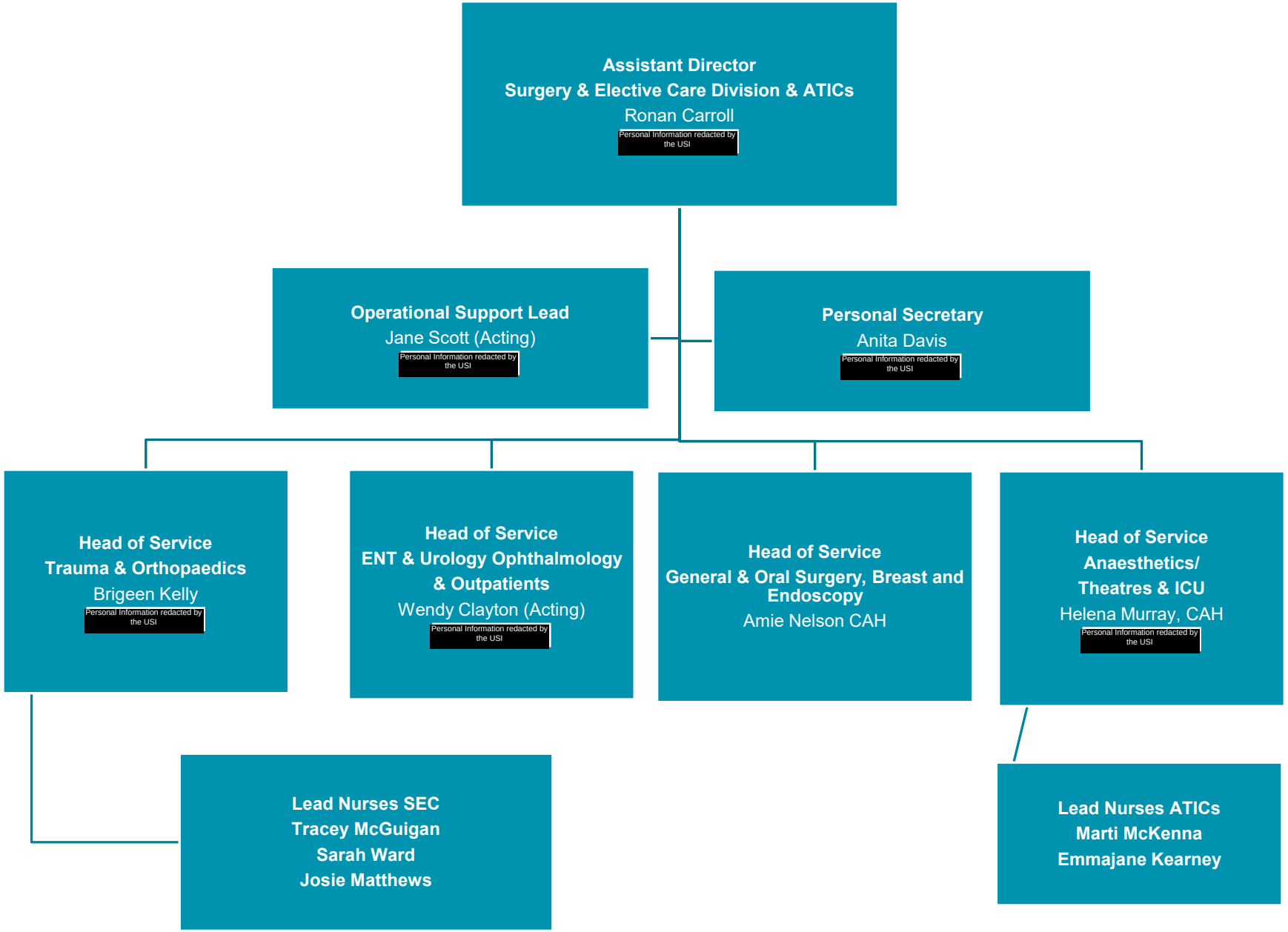
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Directorate of Acute Services

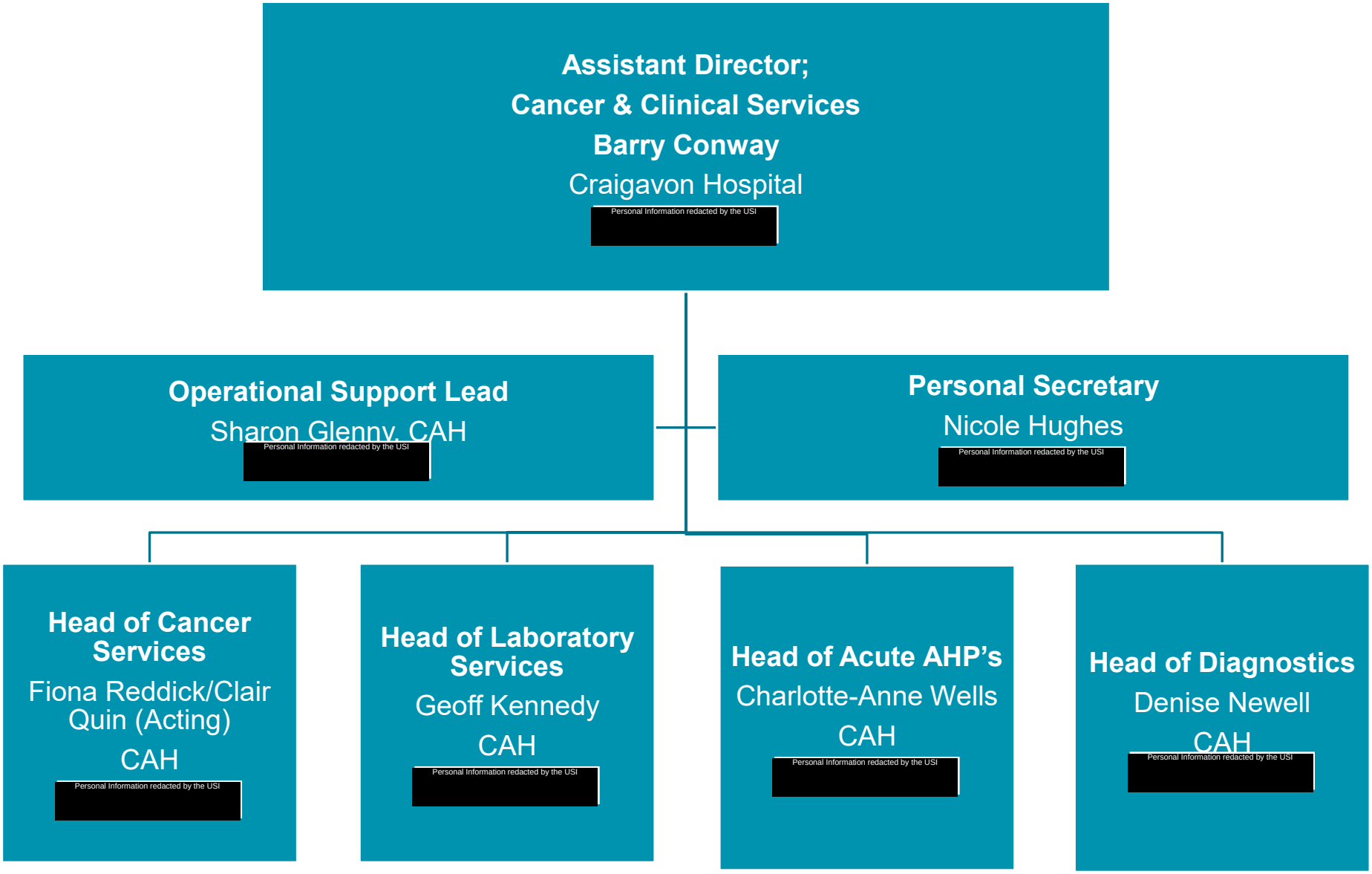
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Directorate of Acute Services

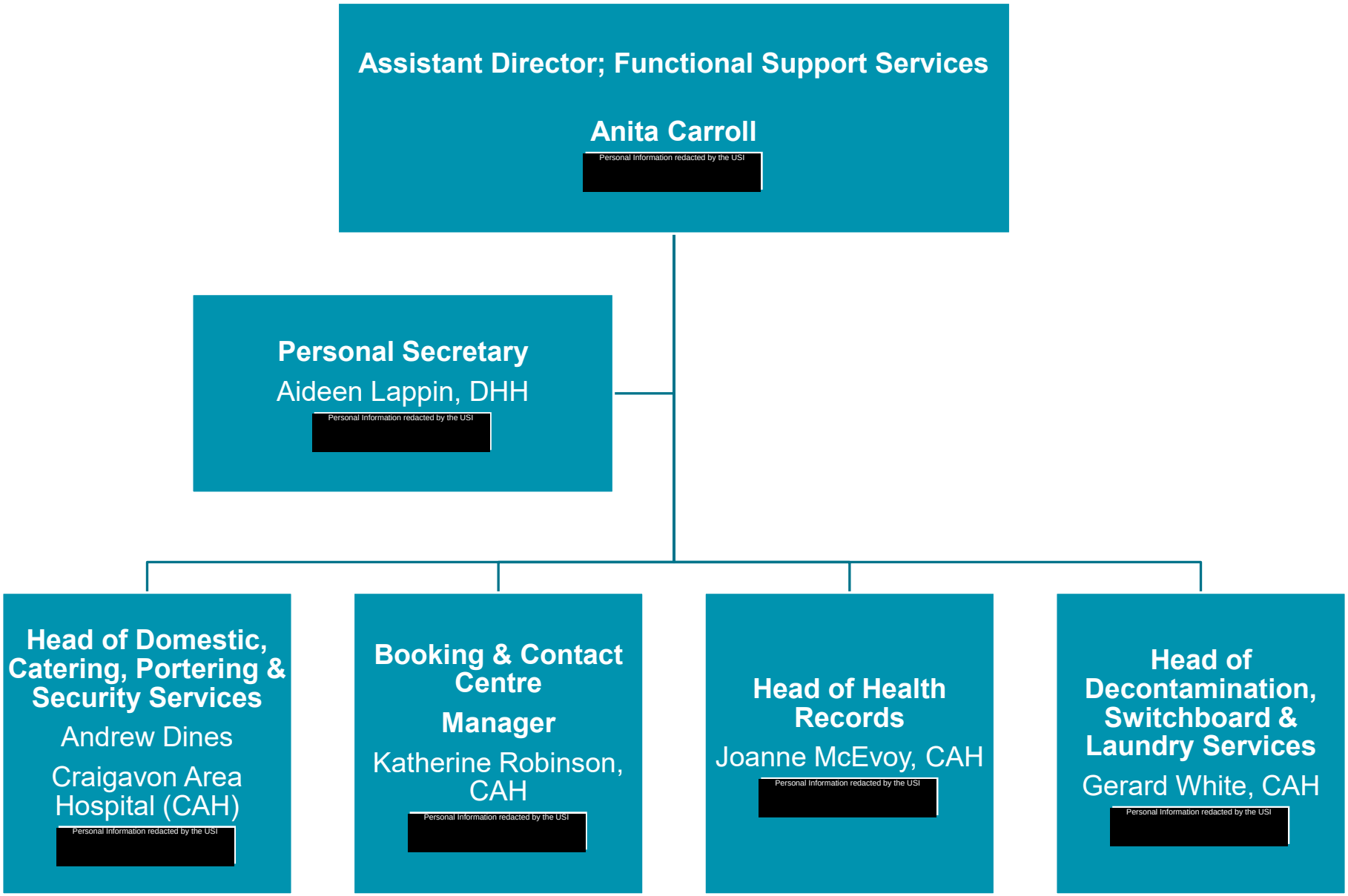
TRU-02072



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Acute Services

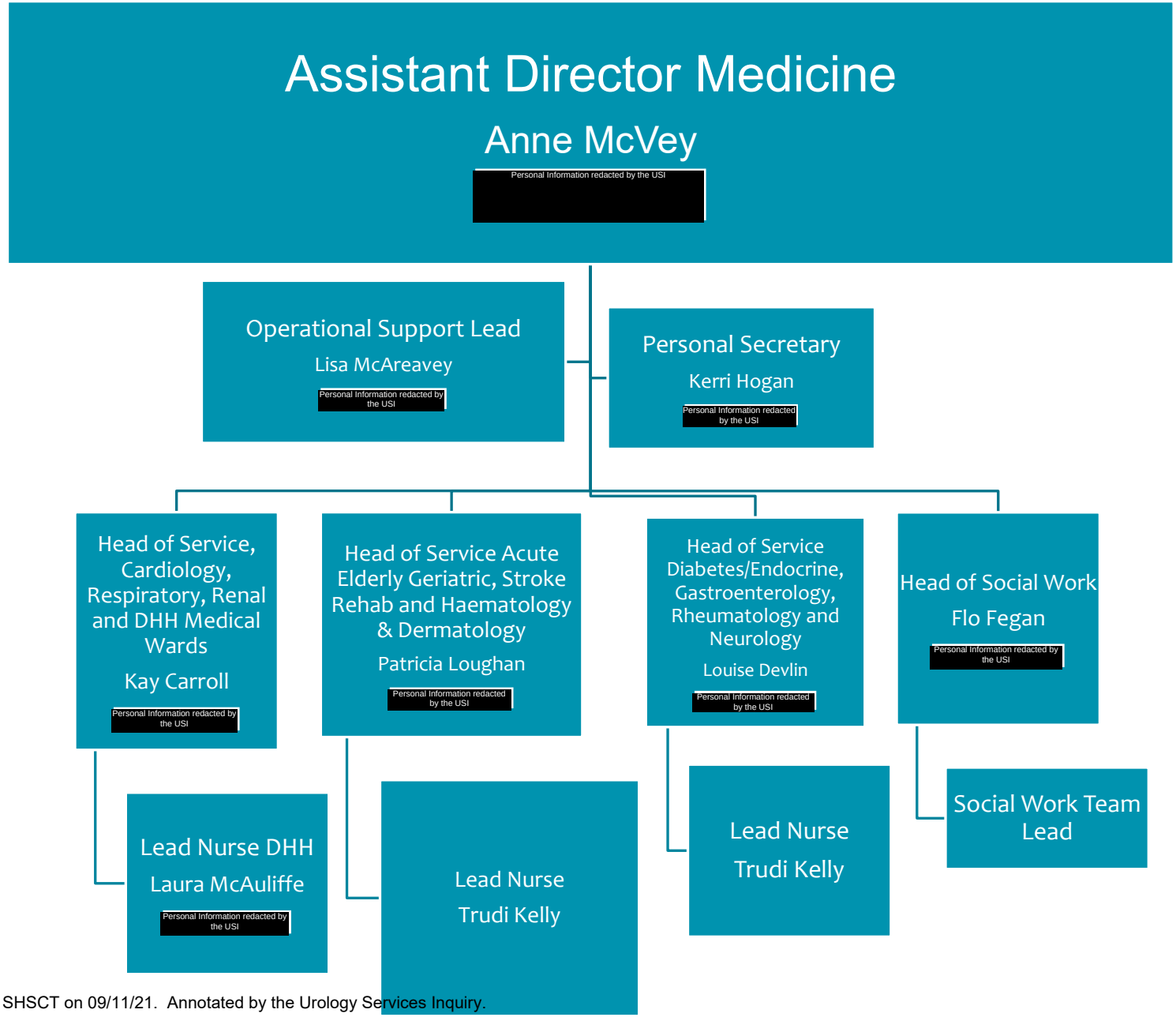
TRU-02073



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Acute Services

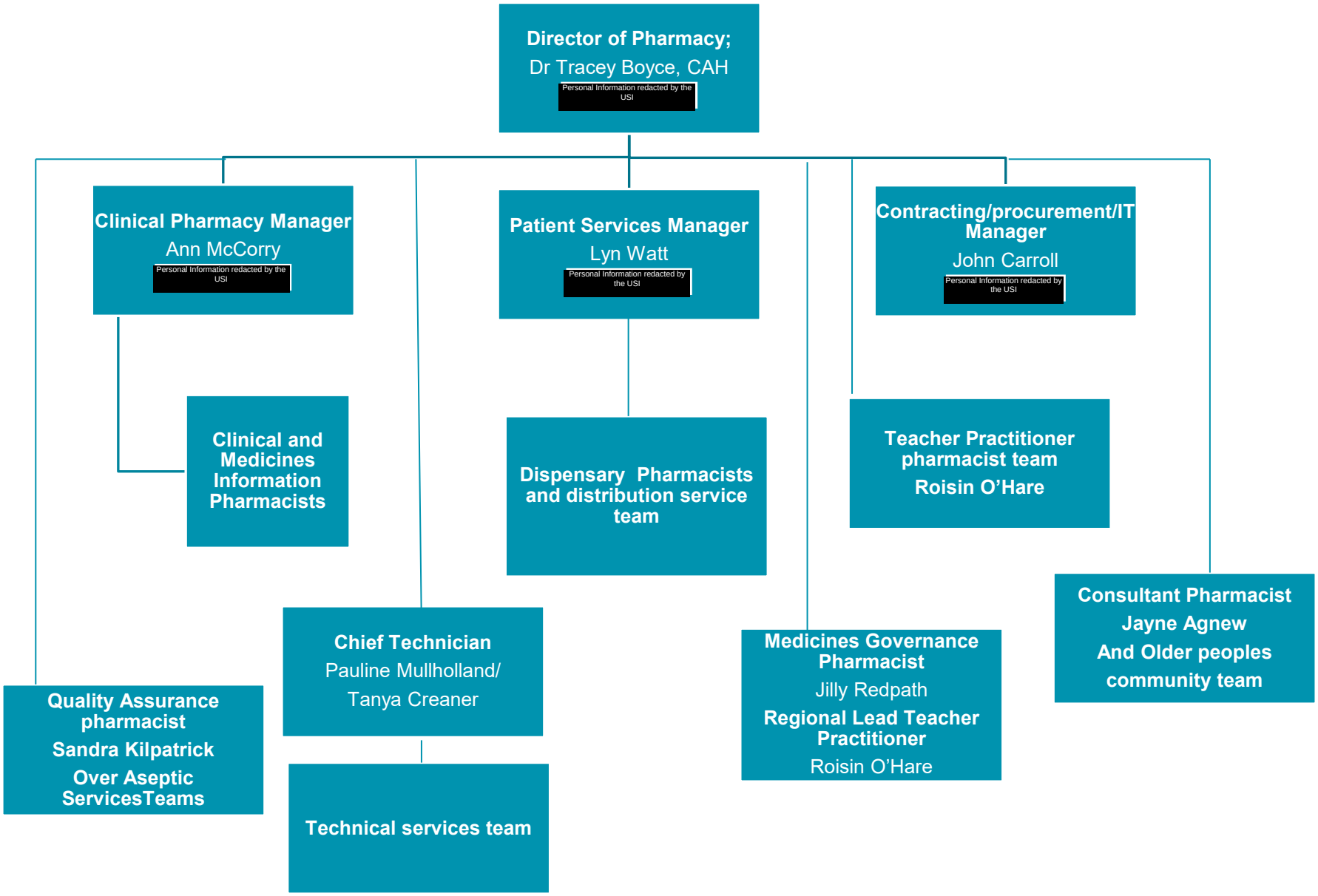
TRU-02074



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Acute Services

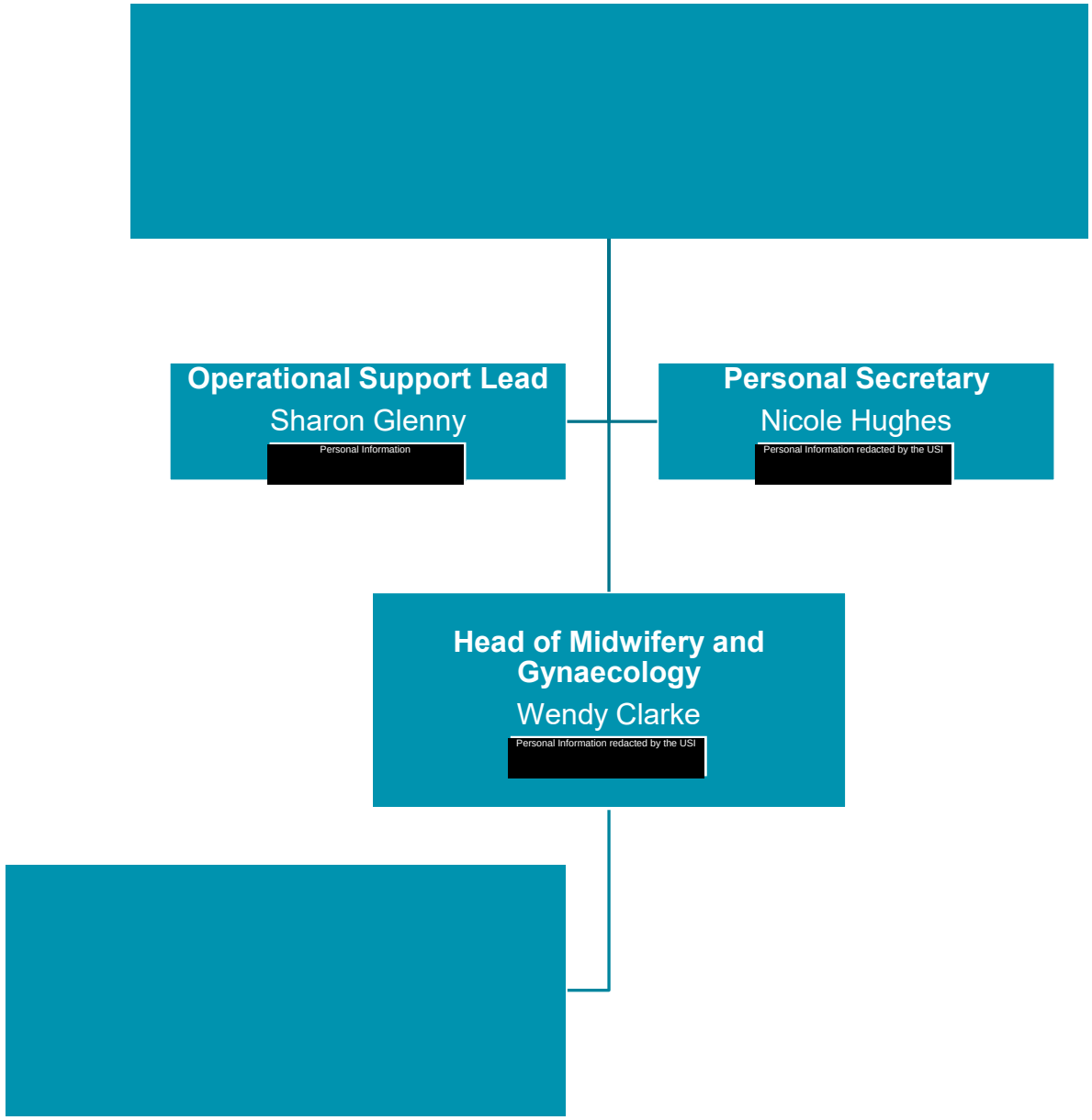
TRU-02075



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

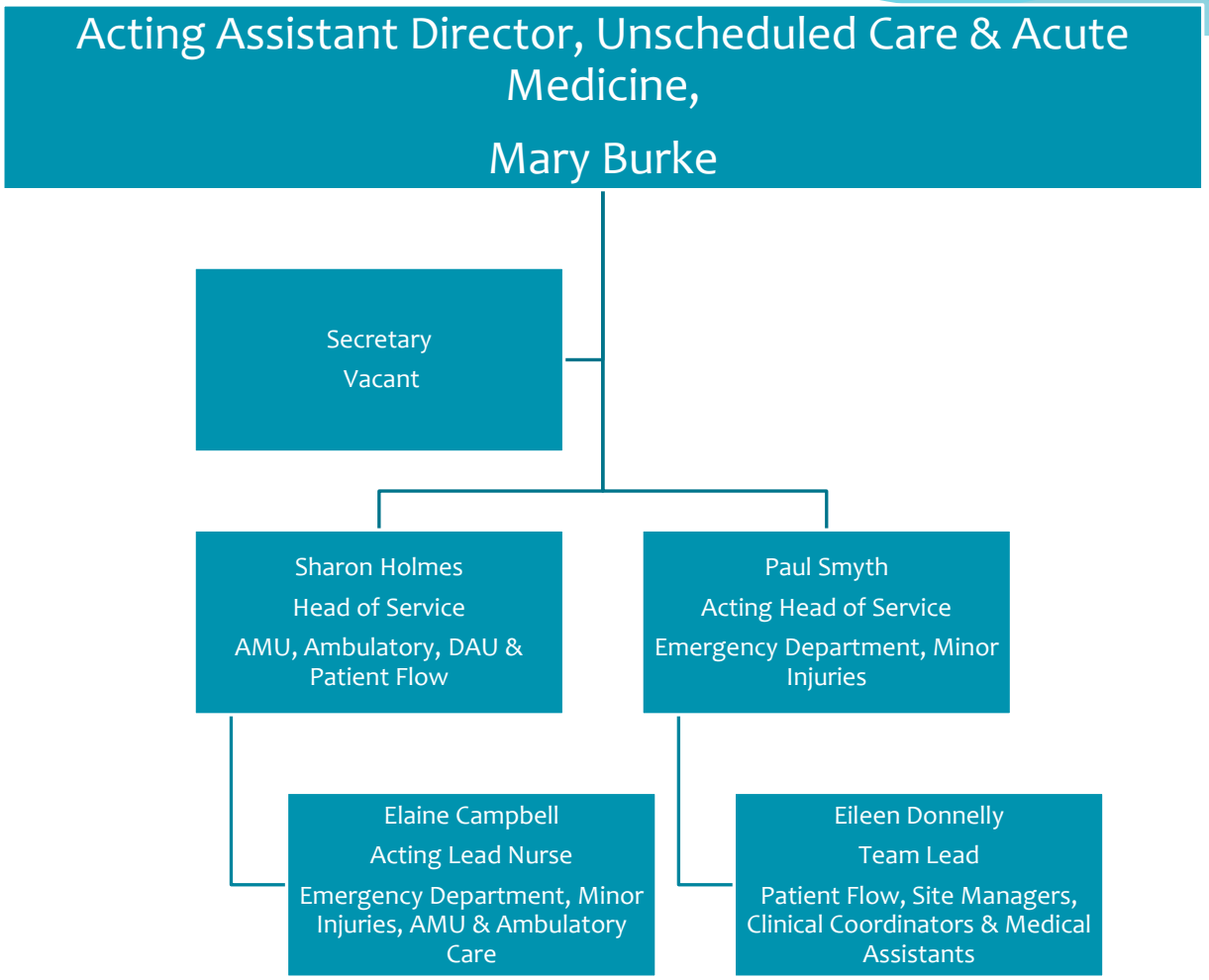
Directorate of Acute Services

TRU-02076



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Acute Services



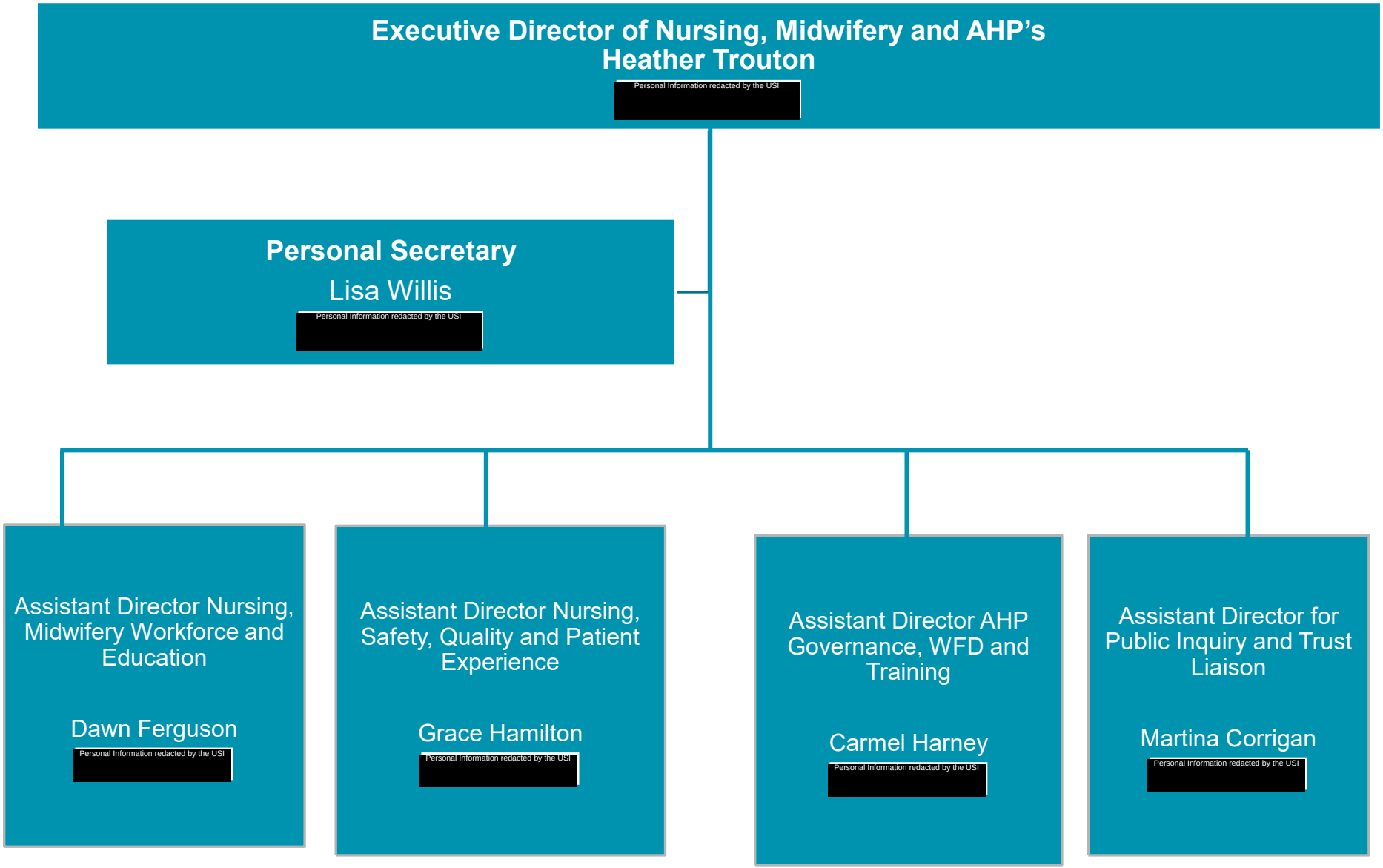
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Interim Executive Director of Nursing, Midwifery and AHP's

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Executive Director of Nursing, Midwifery and AHP's

TRU-02079



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Children and Young Peoples Services

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Children & Young Peoples Services Directorate

TRU-02081

Interim Director Colm McCafferty
Edenderry House, Portadown [redacted]
Personal Assistant Ruth Alexander [redacted]

Associate Medical Director
Dr A McGovern

Assistant Director of Family Support & Safeguarding
Donna Murphy
Edenderry House [redacted]

Assistant Director of Specialist Child Health & Disability
Julie McConville
Edenderry House [redacted]

Assistant Director of Corporate Parenting
Mary Logan
Lisanally House [redacted]

Assistant Director Social Work
(Governance, Workforce Development & Training)
Francesca Leyden
Edenderry House [redacted]

Head of Planning
Paula Vennard, The Brackens, CAH
[redacted]

Finance
Michael Gillespie, Financial Management Accountant
[redacted]

Assistant Director Human Resources
Laura Crilly
Edenderry House [redacted]

Informatics
Karen McCoy, Bannvale House
[redacted]

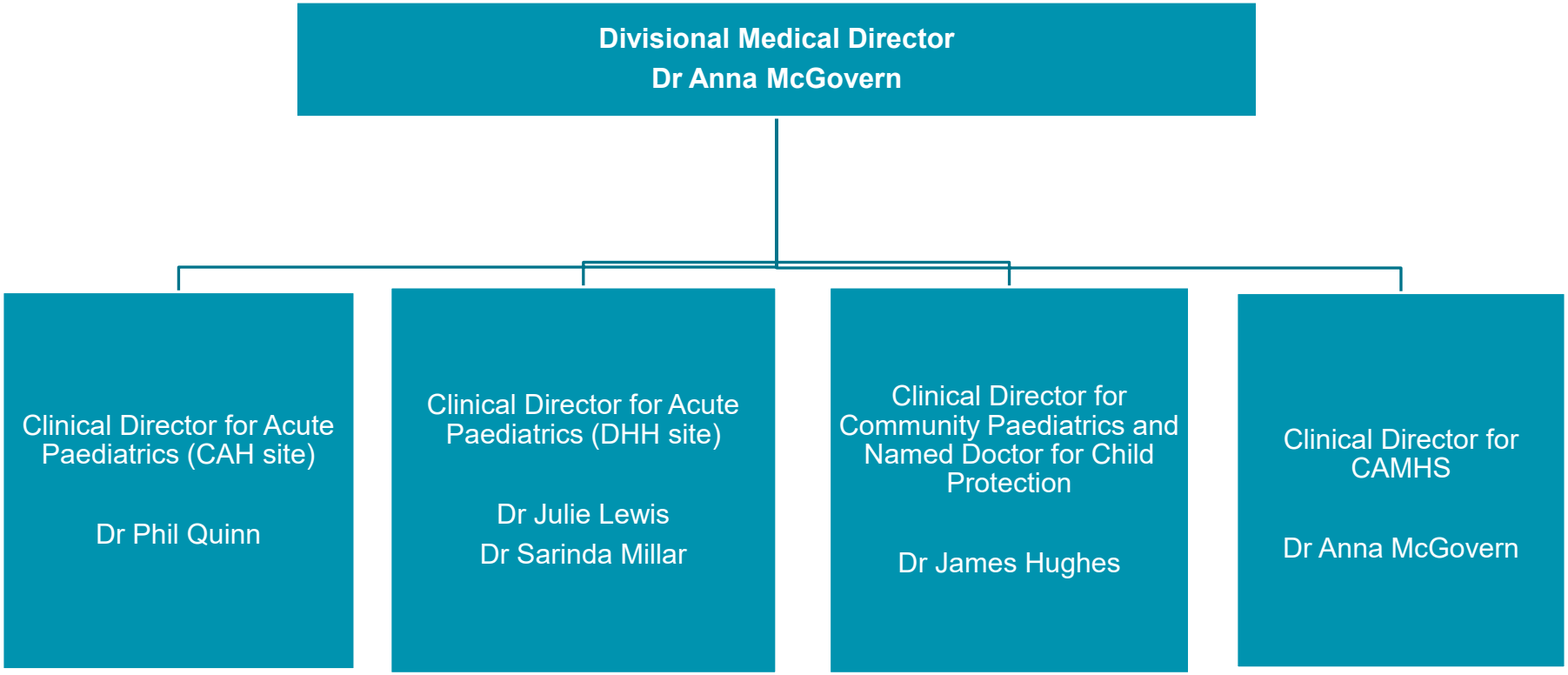
Performance & Reform
Paula Tally, BCBV Programme Manager
Trust HQ, CAH [redacted]

Governance Manager
Marita Magennis
Edenderry House [redacted]

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Children & Young Peoples Services Directorate

TRU-02082



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Children & Young Peoples Services Directorate

TRU-02083

Assistant Director Specialist Child Health & Disability

Julie Mc Conville

Edenderry House, Portadown

Personal Information redacted by the USI

8B Head of Acute Paediatric Services

Bernie McGibbon

Personal Information redacted by the USI

2 NNU Units

2 Paediatric Wards

3 Ambulatory Services

6 Outpatient Service Sites

Acute Admin

8B Head of Community Paediatrics

Joan McMahon (A)

Personal Information redacted by the USI

CCN Service

Specialist Nursing Services – long term condition management

Trustwide SCHD Admin

Trustwide End of Life team

Trustwide Rapid Response/Discharge Team

Clinical Director/ Head of Dental Services

Sarah Foy

Personal Information redacted by the USI

9Community Dental Services

General Anaesthetic Dental Extraction Service

Special Care Dentistry

Comprehensive Care GA Service

Domiciliary Service

Epidemiology

Oral Health Promotion

8B Head of AHP Services and CDC

Sarah Fisher

Personal Information redacted by the USI

Trustwide Core AHP Services

AHP Surestart Services

Paediatric Wheelchair Services

Occupational Therapy Grants Services

School Based AHP Services

Trustwide CDC

8B HOS CAMHS/Autism/ RISE

Shirley Dennison (Acting)

Personal Information redacted by the USI

Single Point of Entry Team

3 Locality based CAMHS teams

1 ACT (Assessment Crisis Team)

1 Community Intensive Treatment Service

3 Primary Mental Health Teams

1 Intellectual Disability CAMHS

Eating Disorder Team

1 Infant CAMHS

Autism Service

Rise Service

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Children & Young Peoples Services Directorate

TRU-02084

Assistant Director Family Support and Safeguarding

Donna Murphy

Edenderry House, Portadown

Personal Information redacted by the USI

Lead for Children's Safeguarding/Public Protection Service/Domestic and Sexual Violence and Abuse

Head of Service Family Support & Safeguarding A&D

Niamh Donnelly Child and Family Care Office

2 Old Lurgan Road

Portadown

Personal Information redacted by the USI

Family Intervention Teams A&D

Adolescent (YPP)/Youth Homeless Service: Trustwide

Lead for Child Protection Practice

Young Carers Lead

Signs of Safety Lead

Head of Service Family Support & Safeguarding C&B

Ciaran Eastwood

Child & Family Care Office

2 Old Lurgan Road, Portadown

Personal Information redacted by the USI

Family Intervention Teams Craigavon, Lurgan & Portadown

Early Years Service Trust Wide

Court Welfare Service :Trust Wide

Sure Starts: Trust wide

Head of Service Family Support & Safeguarding N&M

Leanne Spratt

Dromalane House

Dromalane Road

Newry

BT35 8AP

Personal Information redacted by the USI

Gateway Service Trustwide

Family Intervention Teams N&M, Banbridge

Family Support Hubs; Trust wide

Public Protection Service

CSE / ABE Lead

Head of Health Visiting & School Nursing Family Support & Safeguarding

Mairead Donnelly

Edenderry House, Portadown

Personal Information redacted by the USI

Health Visiting Service: Trustwide

School Nursing Service: Trust wide

NINES : Trustwide

Safeguarding Children's Nurse Service: Trust wide

Family Nurse Partnership: Trustwide

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Children & Young Peoples Services Directorate

TRU-02085

Interim Assistant Director of Corporate Parenting
Mary Logan
Lisanally House, Armagh
Personal Information redacted by the USI

Scaffold Service

Fionnuala McAtamney
Personal Information redacted by the USI

1 Senior
1 Associate
2 Specialist Therapists
3 Primary Mental Health Workers
1 Specialist Nurse LAC
1 Occupational Therapist

Head of Children's Residential Care

Mildred Hollywood
Personal Information redacted by the USI

5 Therapeutic Units
Agency Decision Maker for Children
1 Residential Support Service
Resource Panel

Head of Looked After Children

TBC
Personal Information redacted by the USI

2 x 8a Operational Managers
4 LAC Teams
Concurrent Care Team
Agency Decision Maker for Adults
Permanence Panel

Head of 14+ Services

Stella Kelly
Personal Information redacted by the USI

4 x 16+ Teams
Resource Panel
Historic Abuse Inquiry
Supported & Residential 'Move On' Accommodation

Principal Practitioner for LAC

Supported by:
1 LAC/CC Chair for 14 Plus cases

Head of Service Geraldine Mulholland
Personal Information redacted by the USI

1 x Fostering and Adoption Recruitment and Promotion Team
1 x Inter-Country Adoption Team & post permanence service
Adoption Panel
Matching Panel

Family Placement Assessment and support teams x 2
Fostering panels

Head of Service Children with Disability Service

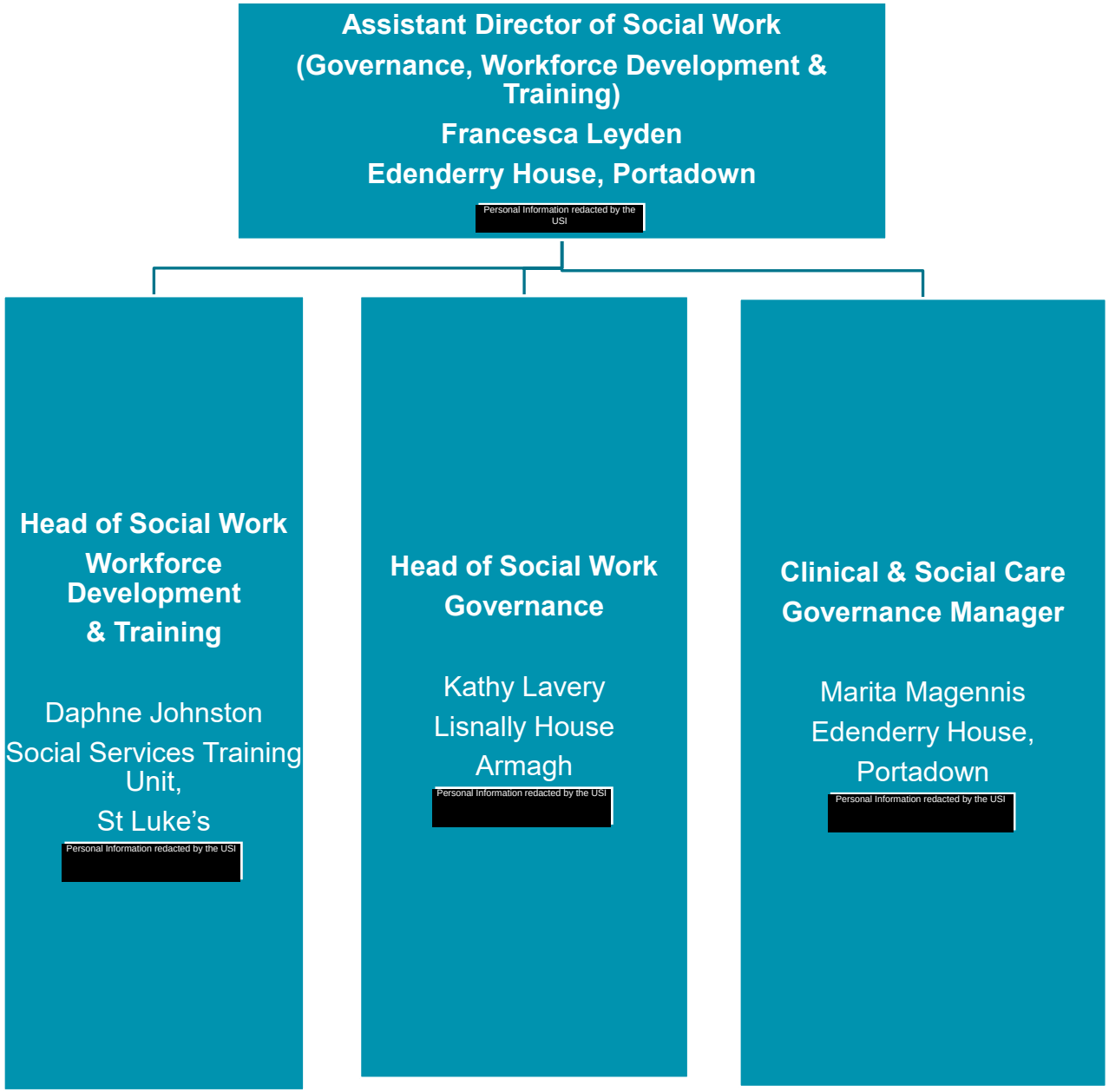
Elaine Mooney
Personal Information redacted by the USI

Trustwide Short Breaks Services
2 Trustwide Short Breaks Units
1 Long Term Residential Unit
1 Trustwide Transition Team
3 Locality based Social WorkTeams
Short Breaks Contracts inc Vol
Short Breaks Unit

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Children & Young Peoples Services Directorate

TRU-02086



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Mental Health and Disability

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

DIRECTORATE OF MENTAL HEALTH & DISABILITY

TRU-02088

DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES (Interim) Dr Maria O'Kane, Bannvale House
Personal Assistant: Mrs Tracy Griffin Personal Information redacted by the USI

Assistant Director Mental Health Services
Jan McGall
Bannvale House
Personal Information redacted by the USI
Secretary – Alberta Hamilton

Assistant Director Disability Services
John McEntee
Bannvale House
Personal Information redacted by the USI
Secretary – Jill Duffy

Assistant Director Mental Health & Learning Disability In-patients
Lynn Woolsey Bluestone Unit, CAH Personal Information redacted by the USI
Secretary – Noleen Campbell

Clinical Director of Psychology Services
Dr Ivor Crothers
Moylinn
Personal Information redacted by the USI
Secretary- Hannah Mc Kinstry

Clinical & Social Care Governance Co-ordinator
Tony Black
Riverside, Bannvale Site
Personal Information redacted by the USI
Secretary Linda Abernethy

Lead Nurse, DMHD
Joe Walker
Personal Information redacted by the USI

Lead Social Worker, DMHD
Kathy Lavery
Personal Information redacted by the USI

Lead AHP, DMHD
Karen McCann
Personal Information redacted by the USI

Associate Medical Director
Dr Pat McMahon
Bluestone Unit, CAH
Personal Information redacted by the USI
Secretary Lisa Gallagher

Clinical Director General Adult Psychiatry
Dr Joanne Minay
Bluestone Unit, CAH
Personal Information redacted by the USI
Secretary – Annette Gribben

Clinical Director Learning Disability and Physical/Sensory Disability
Dr Arun Subramanian
St Luke's, Armagh
Personal Information redacted by the USI
Secretary – post vacant

Head of Adult Safeguarding
Deborah Hanlon
Personal Information redacted by the USI
Admin Support: Sinead Nugent

Assistant Director Human Resources
Jenny Johnston
Bannvale House
Personal Information redacted by the USI
Secretary – Linda Abernethy

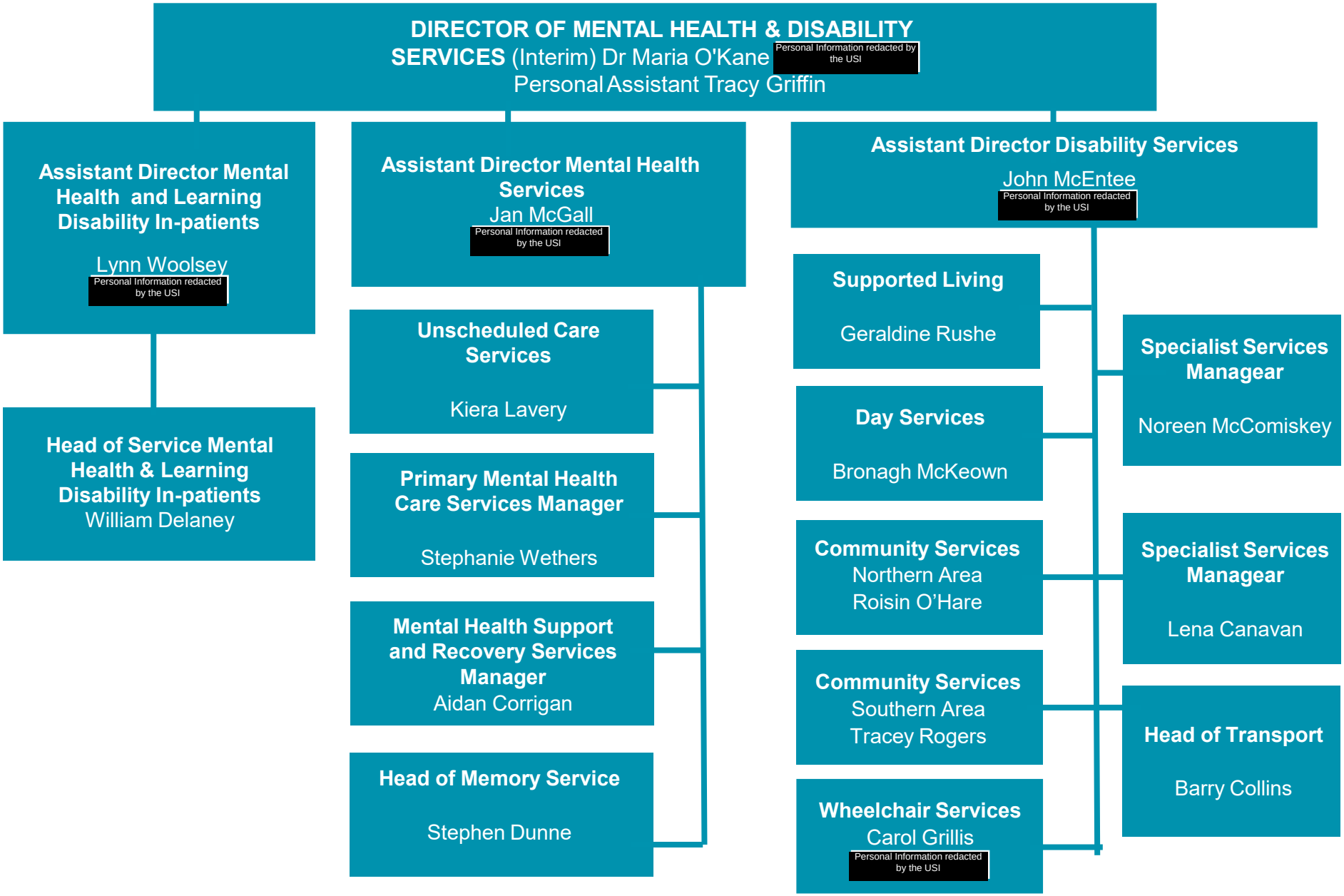
Senior Financial Management Accountant
Dean Faloon
Lurgan Hospital
Personal Information redacted by the USI

Head of Planning
Claire Kelly
The Brackens, CAH Site
Personal Information redacted by the USI

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Mental Health & Disability Services Ad's & HoS

TRU-02089



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Mental Health Division

TRU-02090



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Mental Health Division

TRU-02091

Assistant Director Mental Health Services
Jan McGall
Personal Information redacted by the USI

Operational Support Lead
Ann McGhee

Service Improvement Manager
Post vacant

Towards Zero Suicide Co-ordinator
Liz McGrath

Unscheduled Care Services
Kiera Lavery

- **Integrated Liaison Co-ordinator**
  Julie Stewart
- **Home Treatment Care Co-ordinator**
  Post vacant
- **Perinatal MH Health Lead**
  Post vacant

Primary Mental Health Care Services Manager
Stephanie Wethers

- **PMHC Co-ordinator**
  Leah-Ann Shanks
- **Addiction Network Co-ordinator**
  Lydia Scholes
- **CMP & Talking Therapies Co-ordinator**
  Adrian Cluett
- **CBT Service Manager**
  Niamh Trainor

Mental Health Support and Recovery Services Manager
Adrian Corrigan

- **S & R Services Co-ordinator C&B**
  Ciara Campbell
- **S & R Services Co-ordinator A&D**
  Danny McIlory
- **S & R Services Co-ordinator N&M**
  Adrian Cluett
- **Clinical Lead OT for MH**
  Leah Green

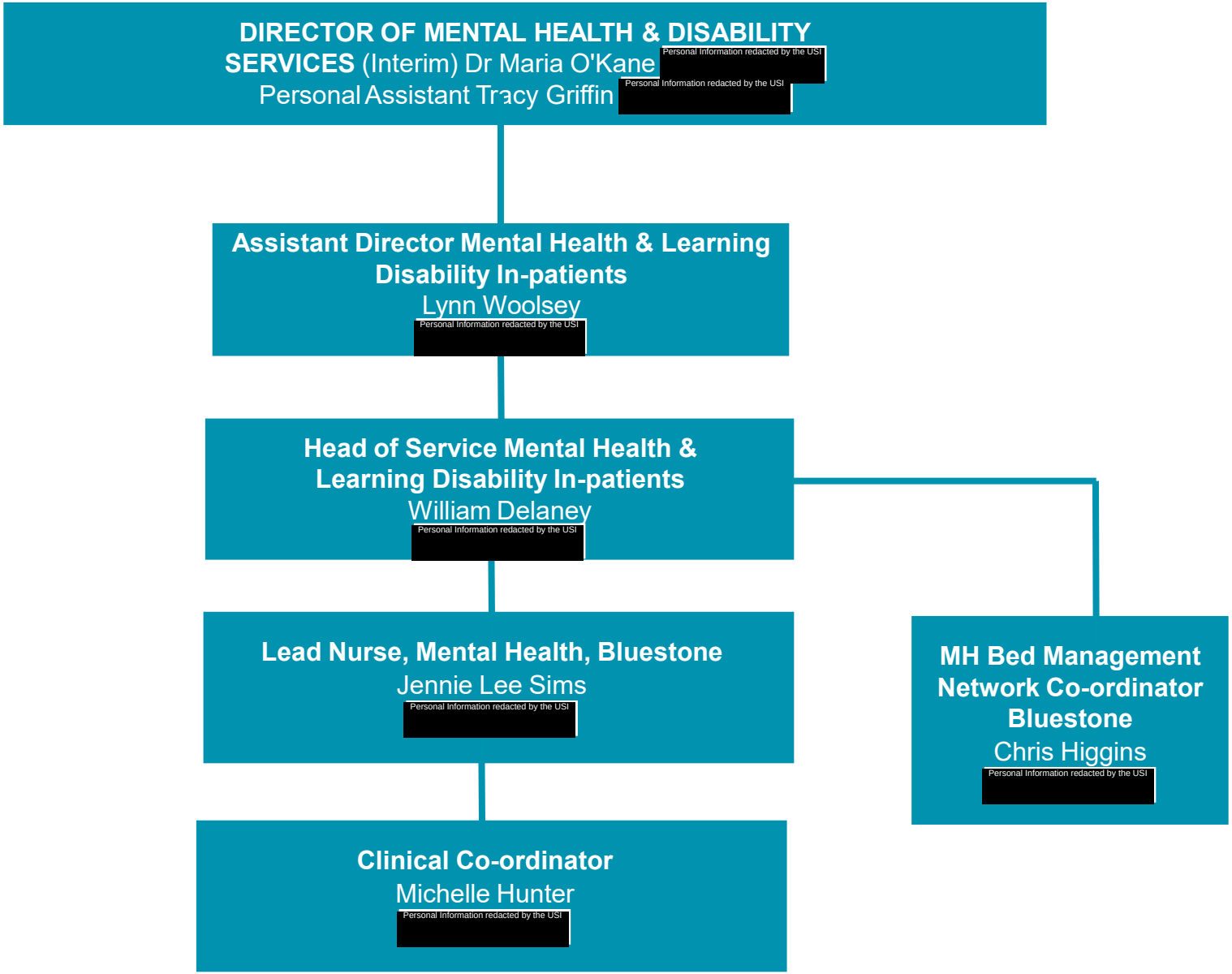
Head of Memory Service
Stephen Dunne

- **Dementia Services Co-ordinator Gillis**
  Gayle Murphy
- **Dementia Services Co-ordinator Community**
  Lindsay Porter
- **Service Improvement Lead**
  Deirdre McKenna (on secondment)

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Mental Health Division In-Patients

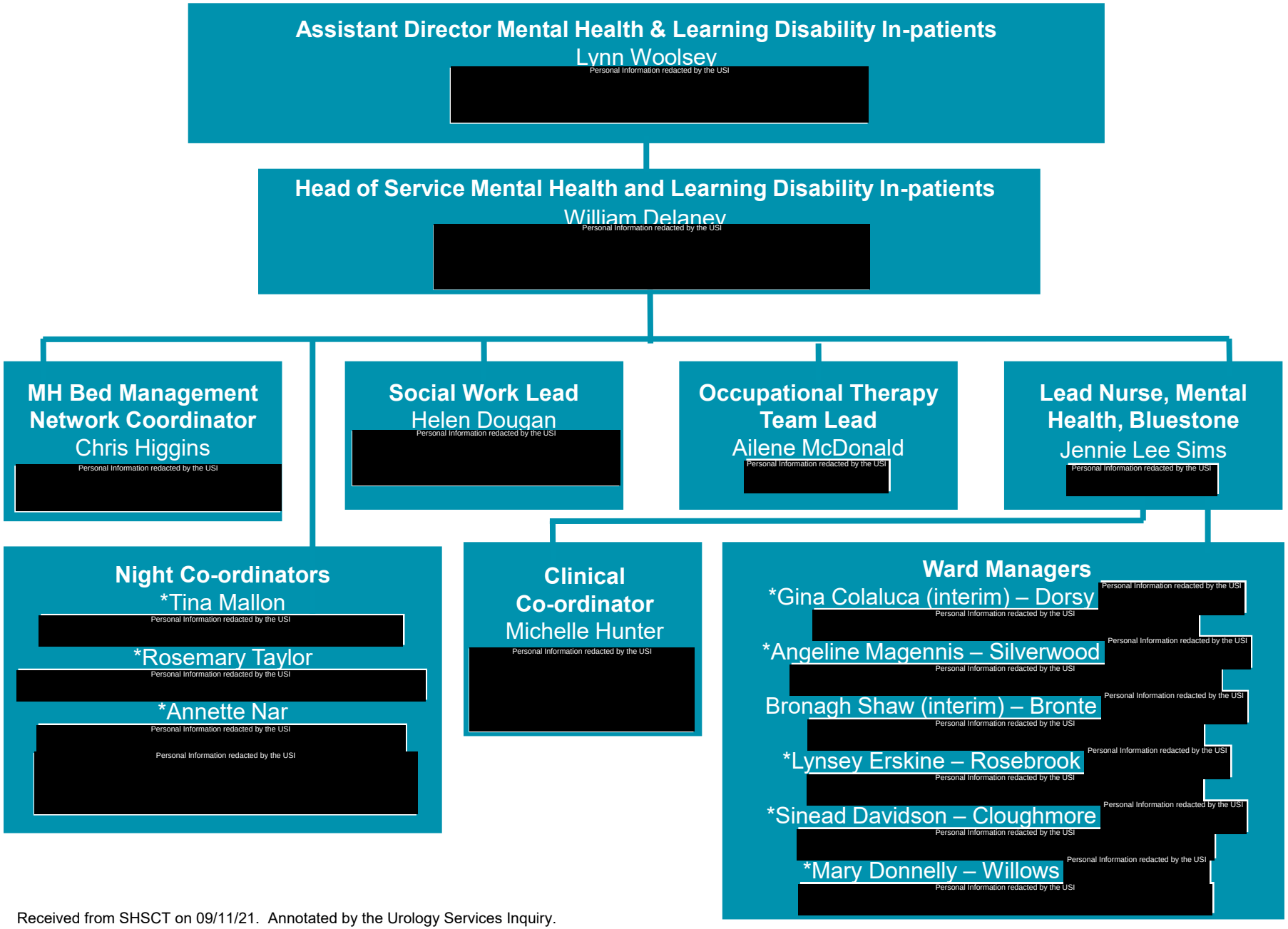
TRU-02092



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Mental Health Division In-Patients

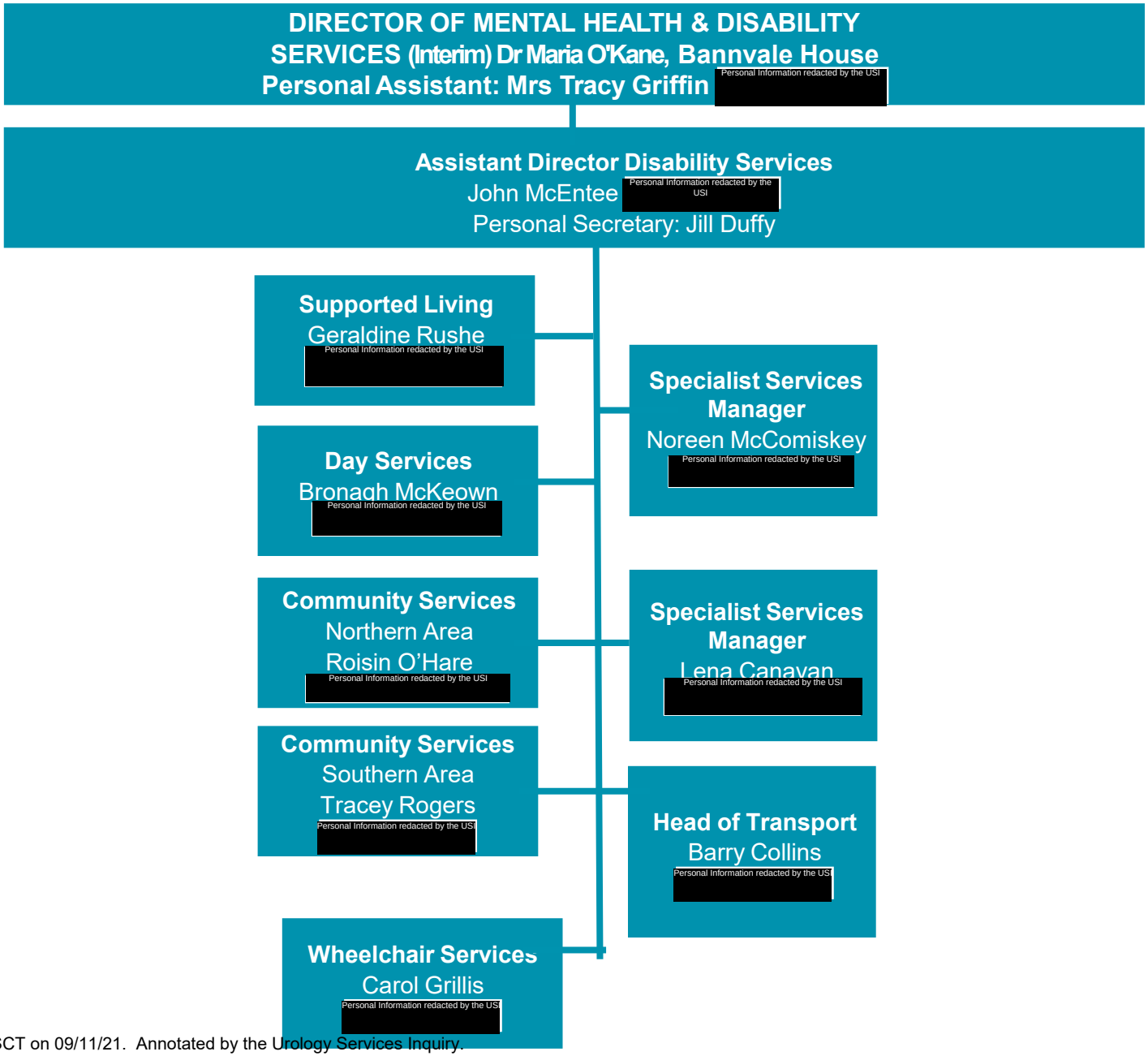
TRU-02093



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Disability Division

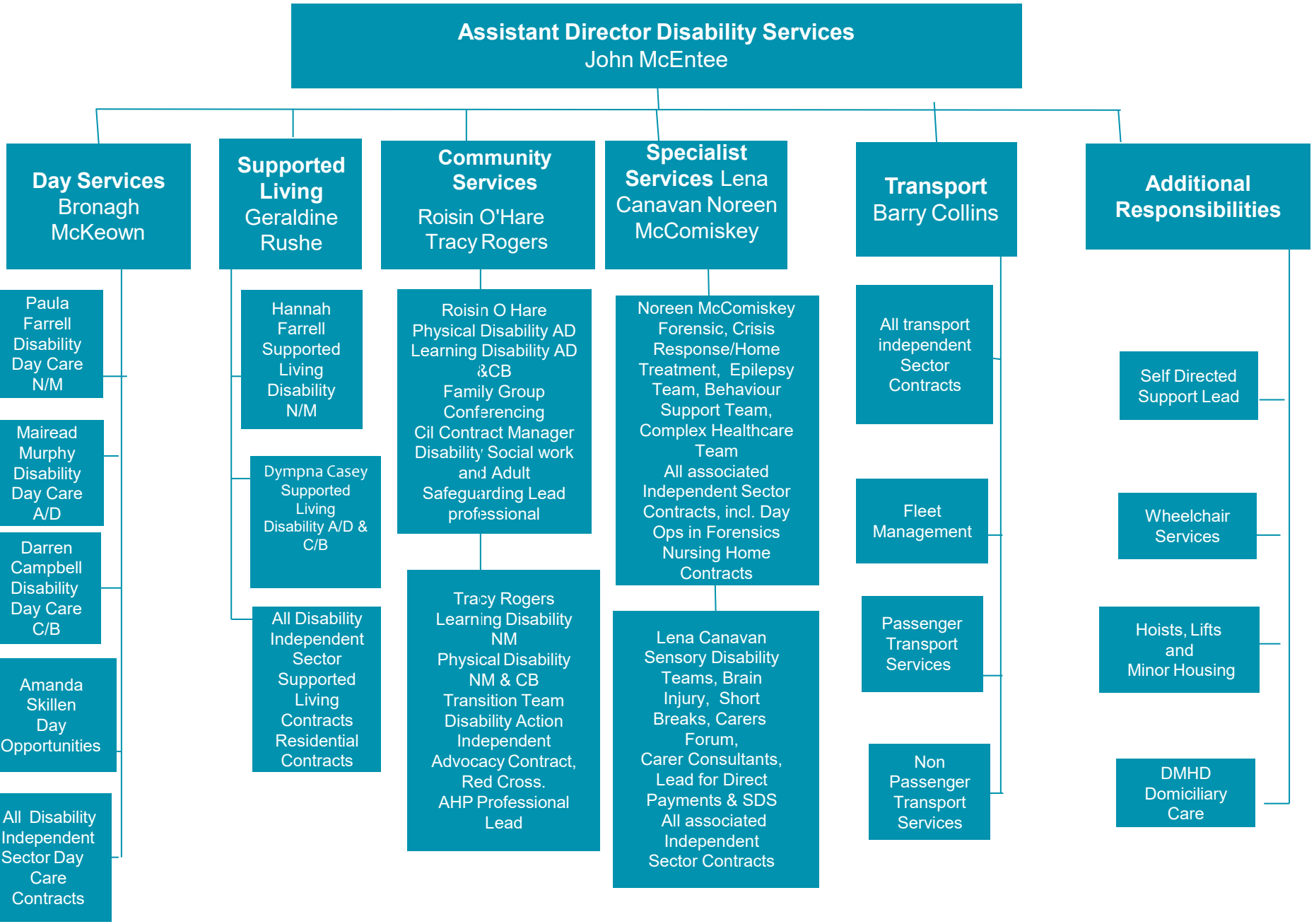
TRU-02094



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Disability Division

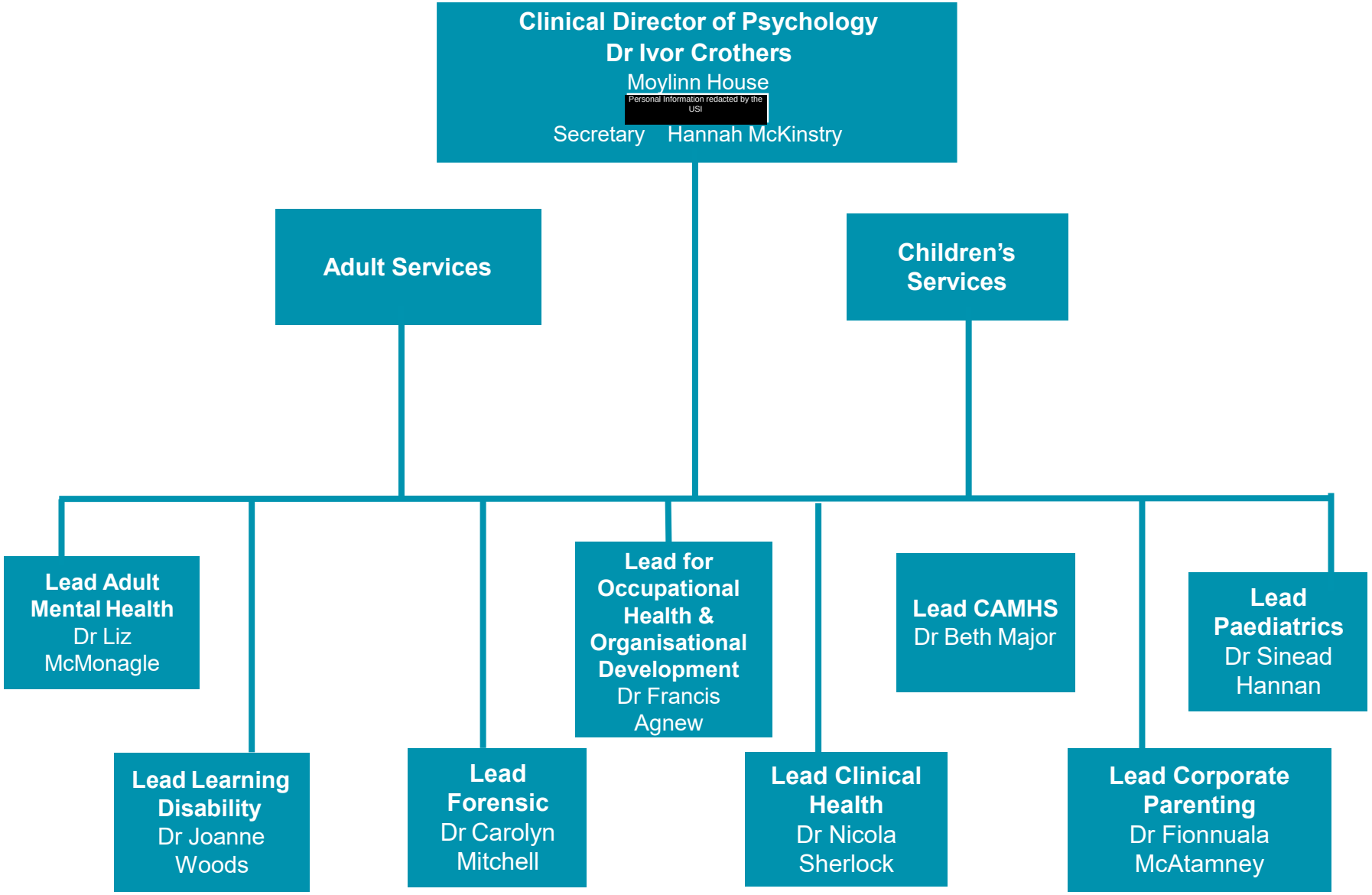
TRU-02095



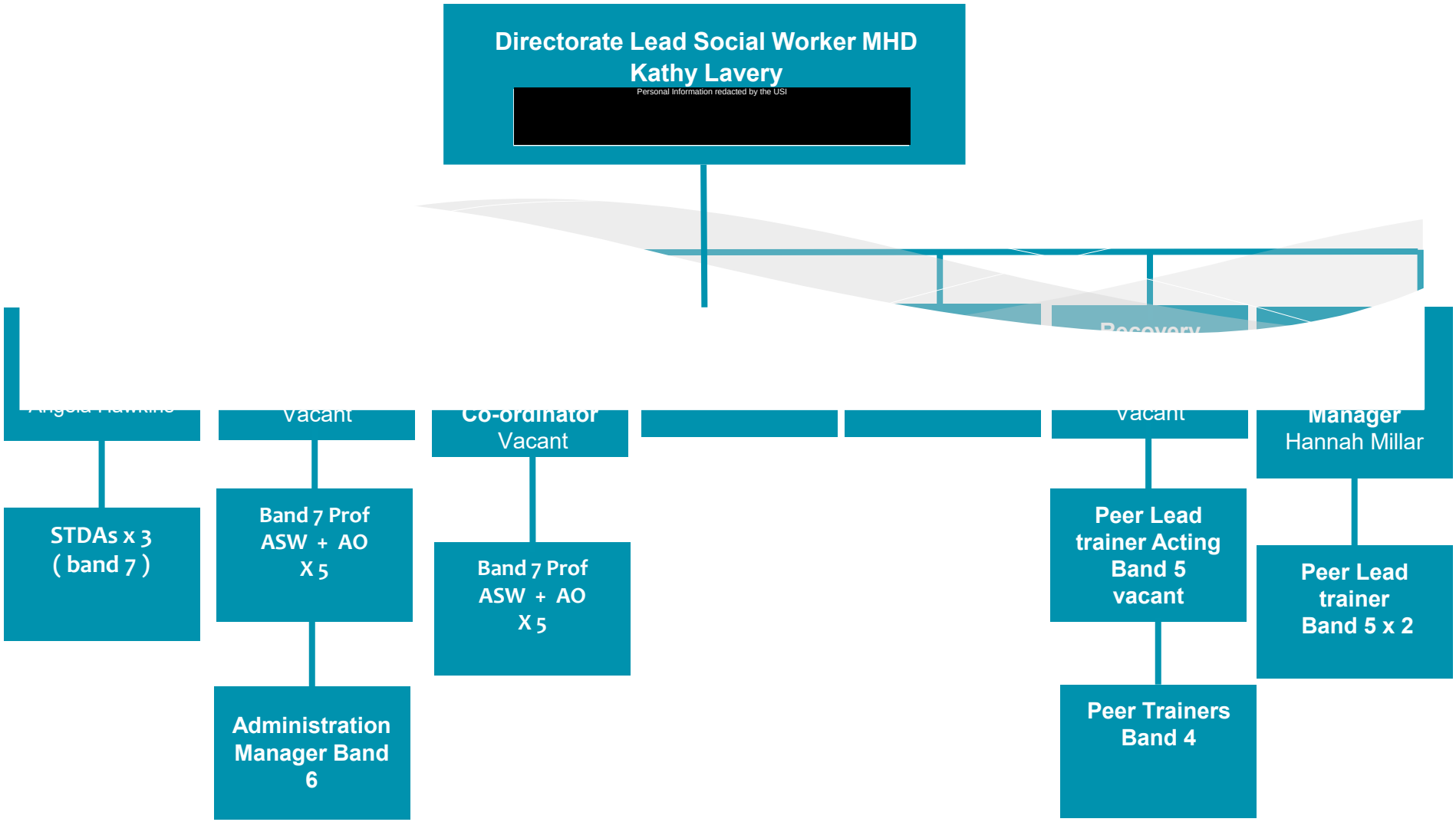
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

SHSCT Psychology Services

TRU-02096



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.



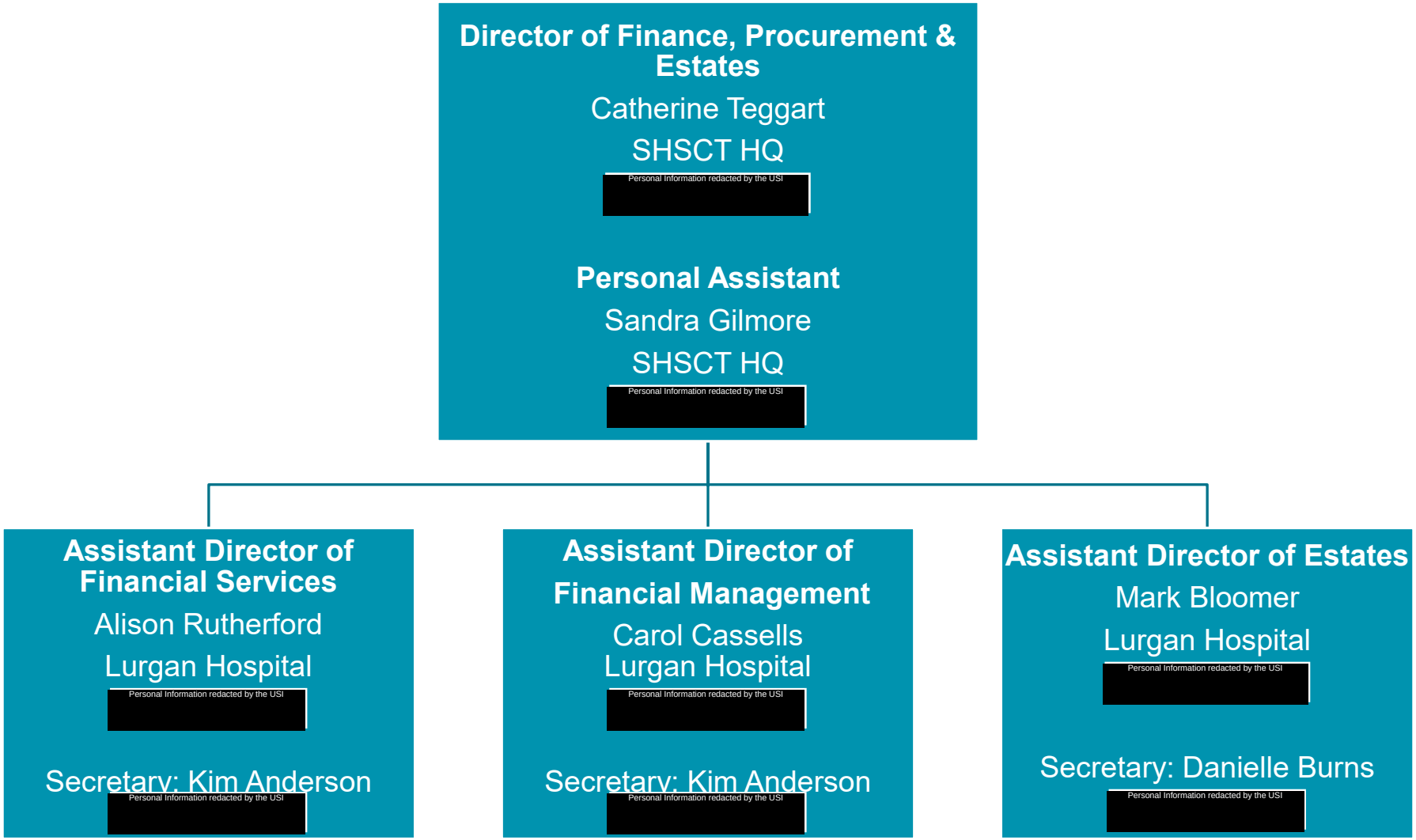
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Finance, Procurement & Estates

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Finance, Procurement & Estates

TRU-02099



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Finance, Procurement & Estates

TRU-02100

Assistant Director of Financial Services
Alison Rutherford
Lurgan Hospital
Personal Information redacted by the USI

Head of Financial Services
Helen O'Hare
Daisy Hill Hospital
Personal Information redacted by the USI

(Acting) Head of Financial Accounting & Systems
Julie E Brown
Lurgan Hospital
Personal Information redacted by the USI

Danny O'Prey
Lurgan Hospital
Personal Information redacted by the USI

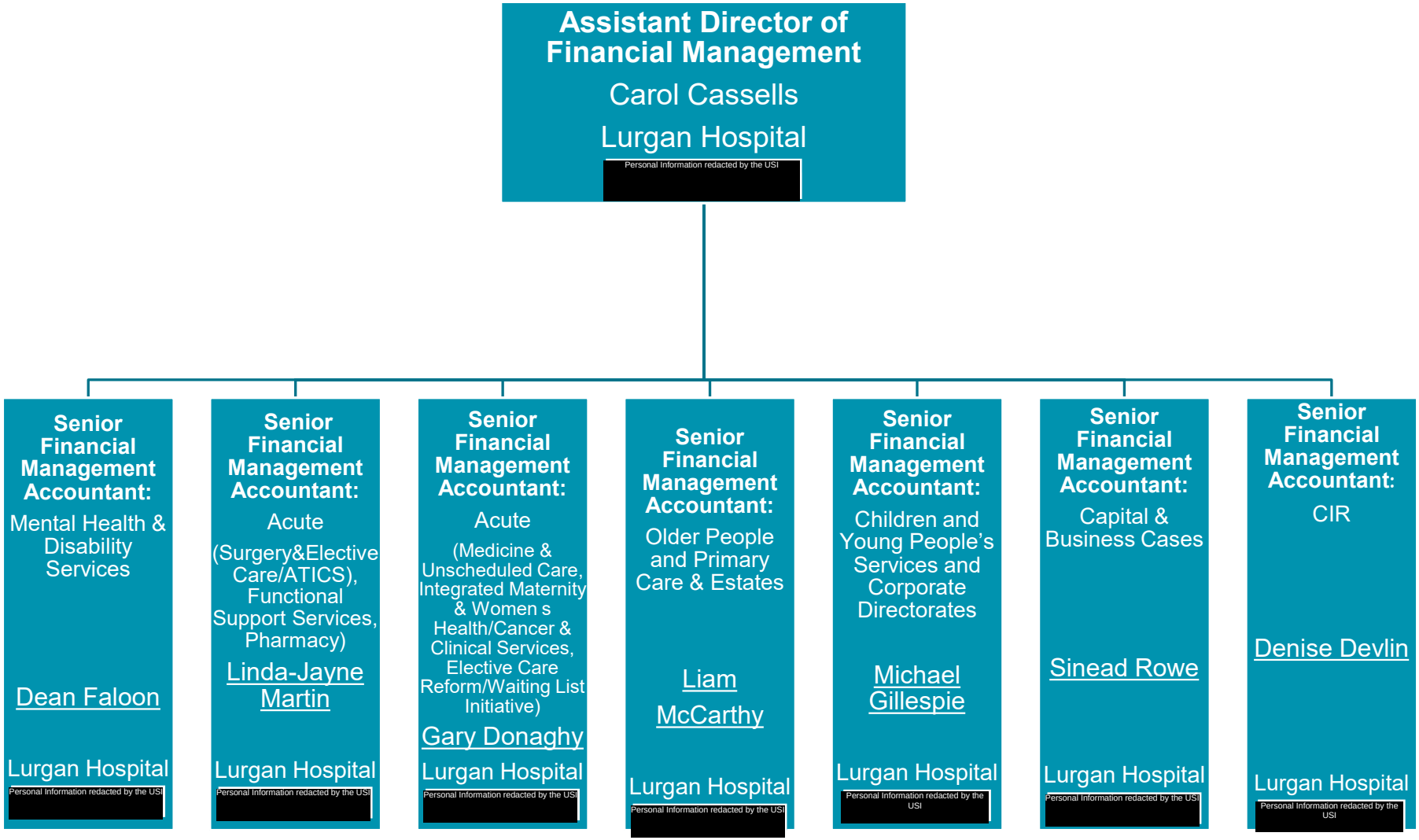
Corporate Financial Accountant / Fraud Liaison Officer
Fiona Jones
Lurgan Hospital
Personal Information redacted by the USI

Procurement & Supply Chain Manager
Paul Kelly
Craigavon Area Hospital
Personal Information redacted by the USI

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Finance, Procurement & Estates

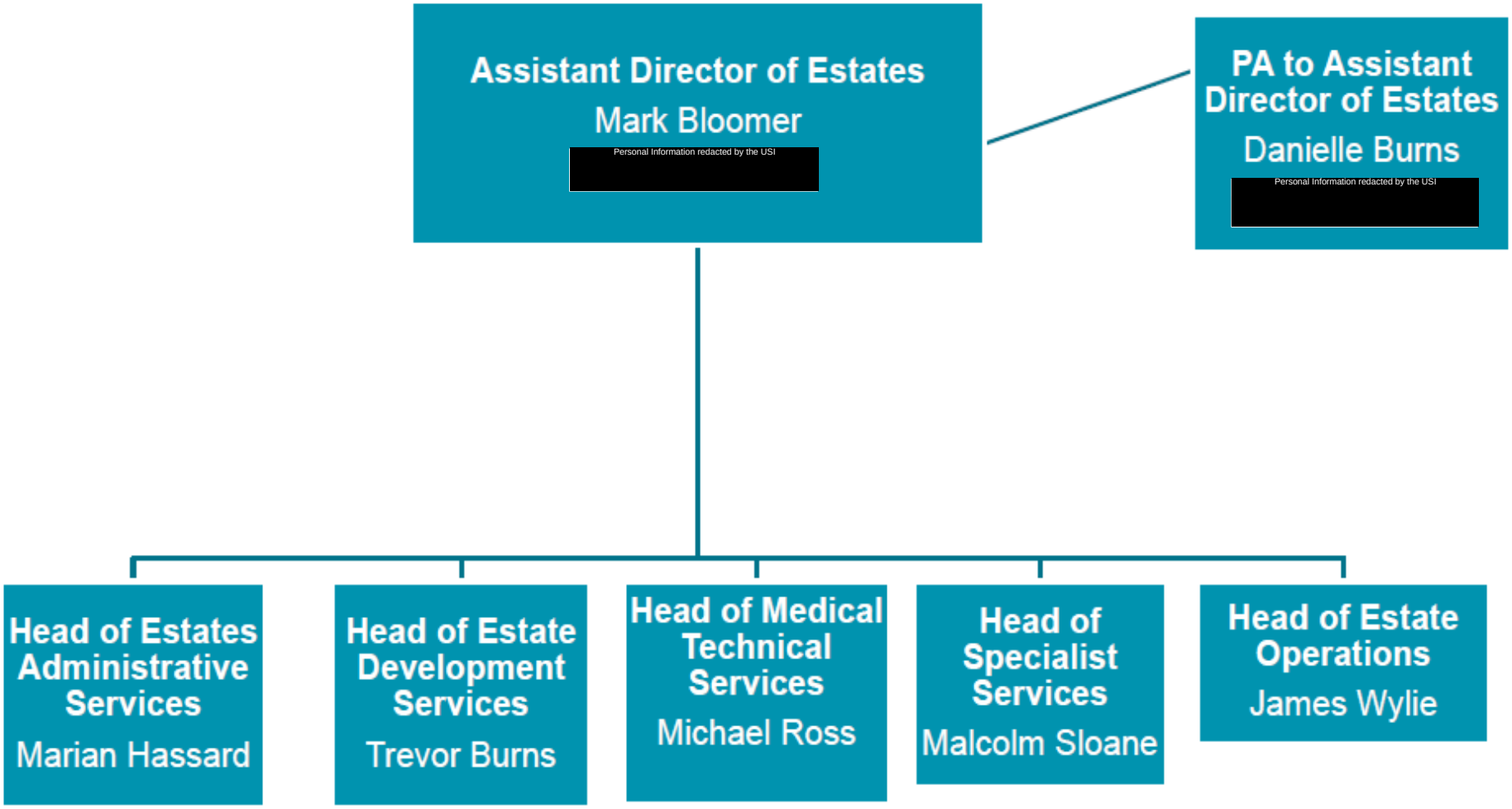
TRU-02101



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Finance, Procurement & Estates

TRU-02102

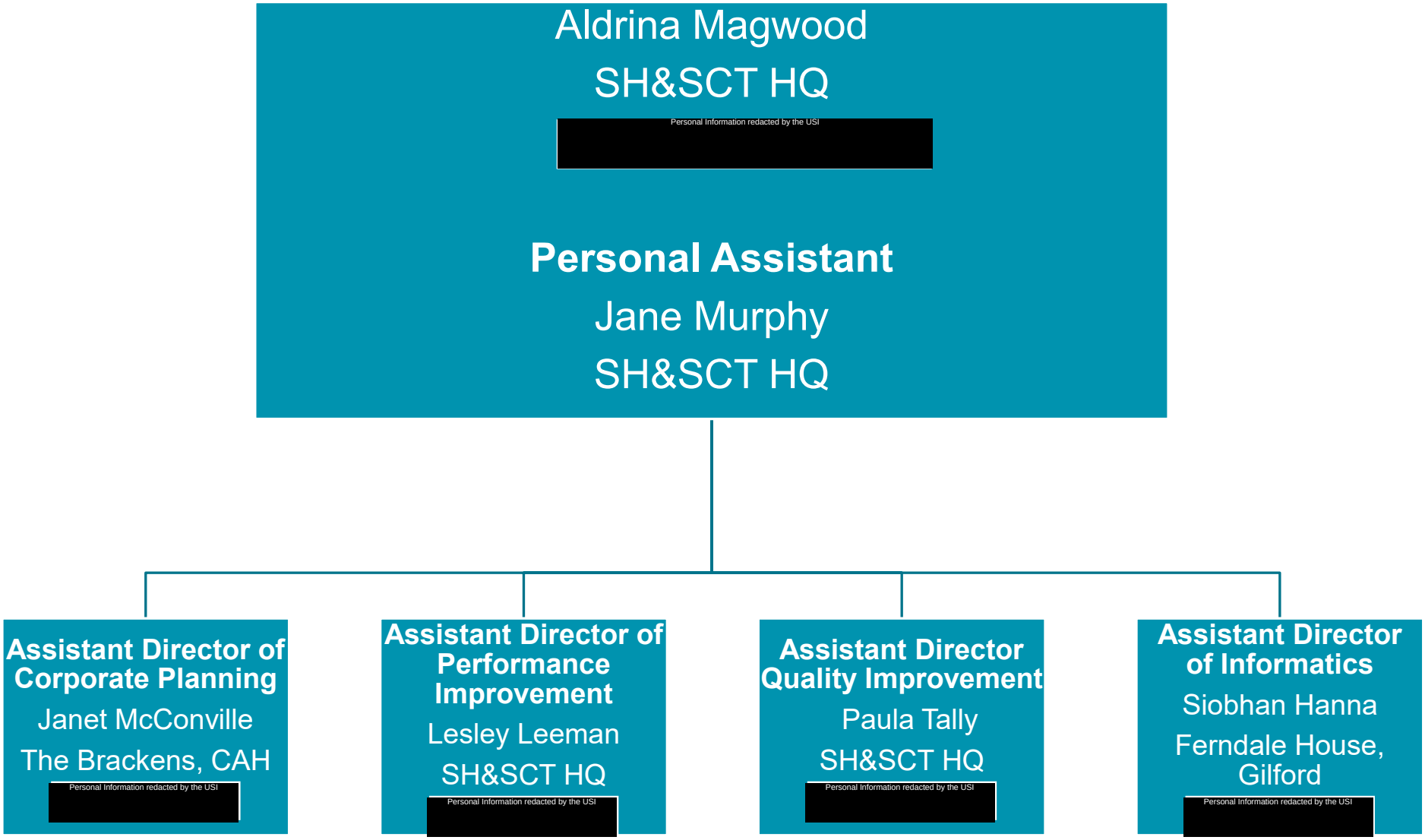


Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Performance and Reform

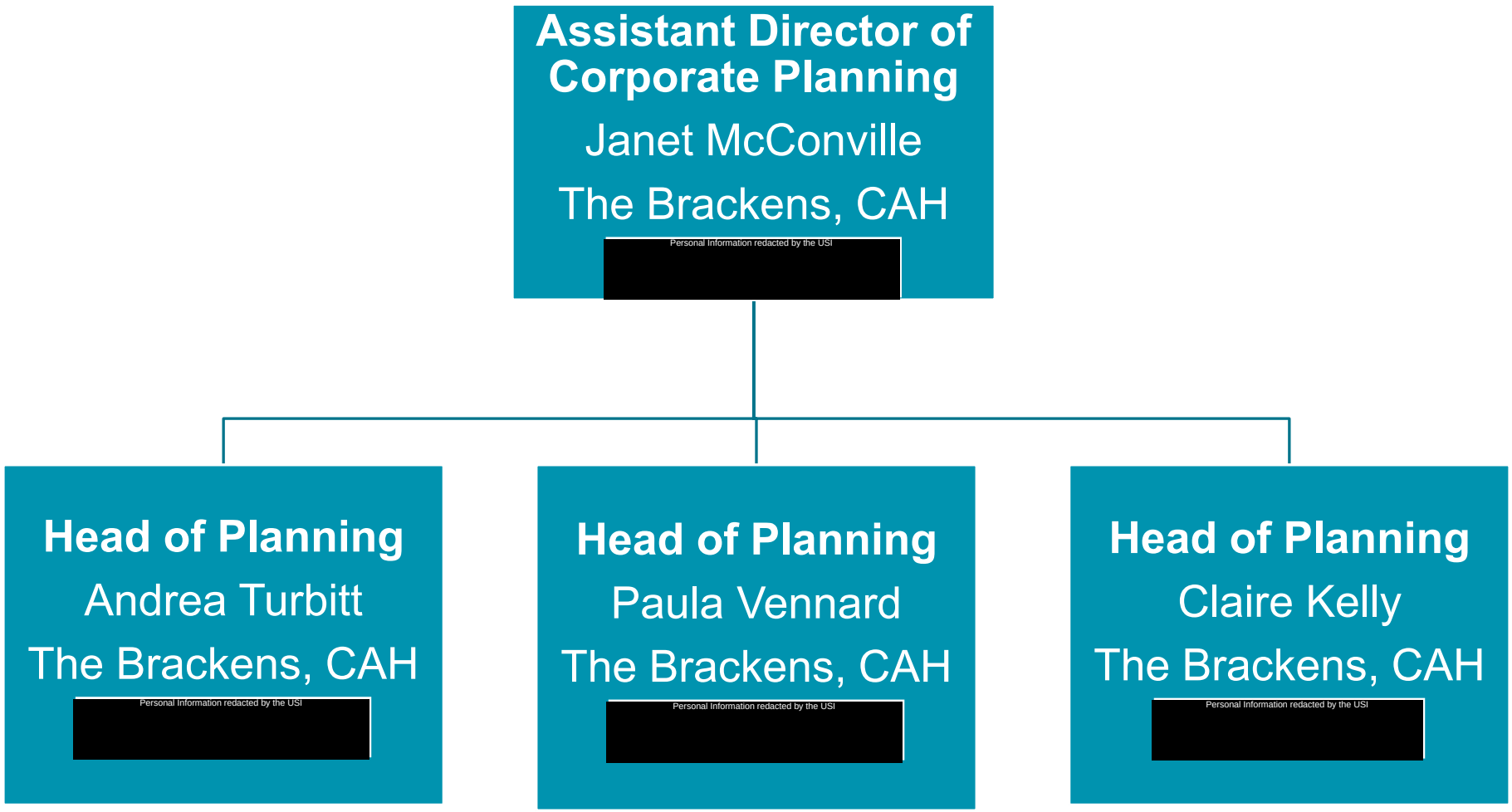
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Performance and Reform TRU-02104



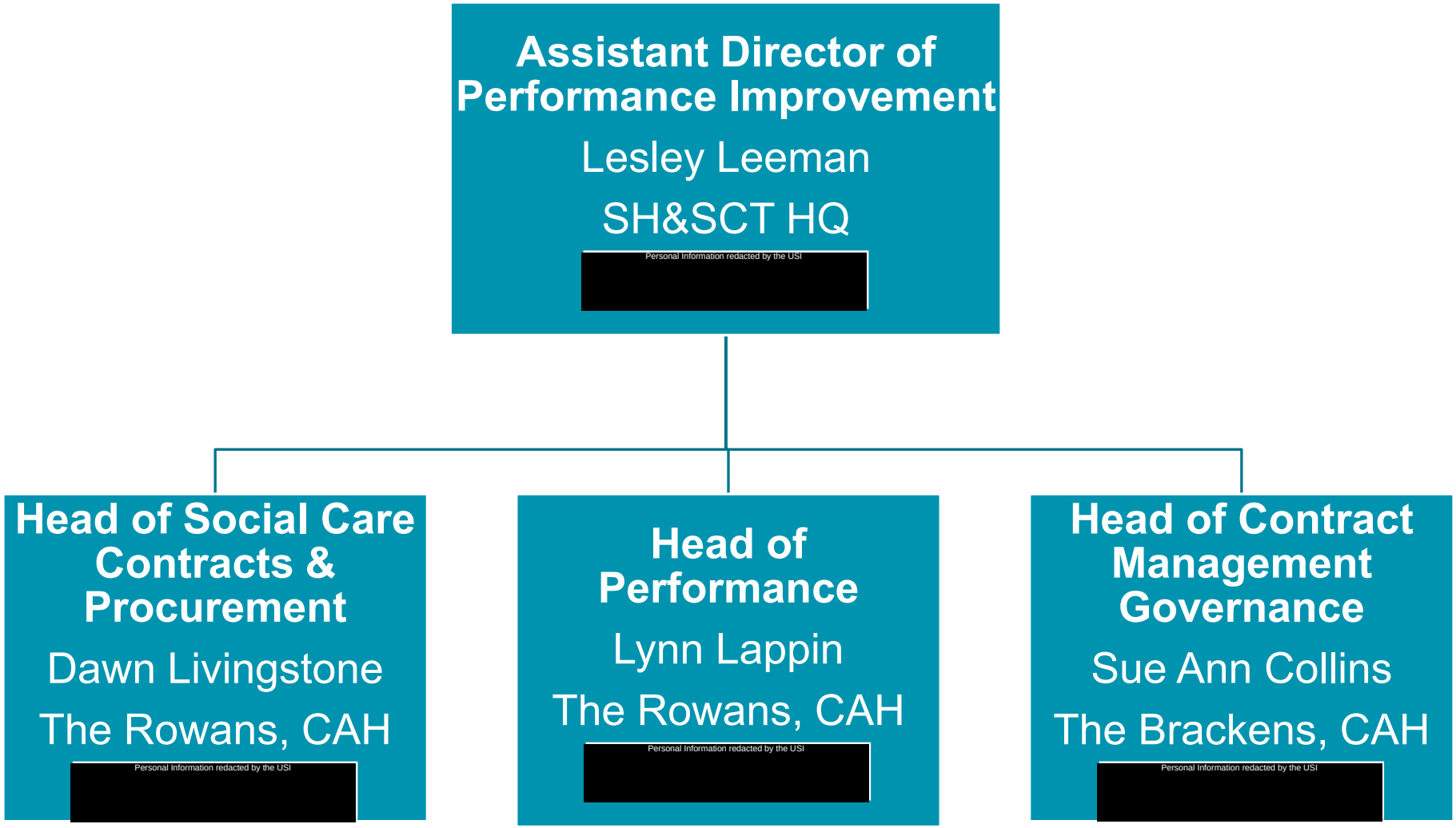
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Performance and Reform TRU-02105



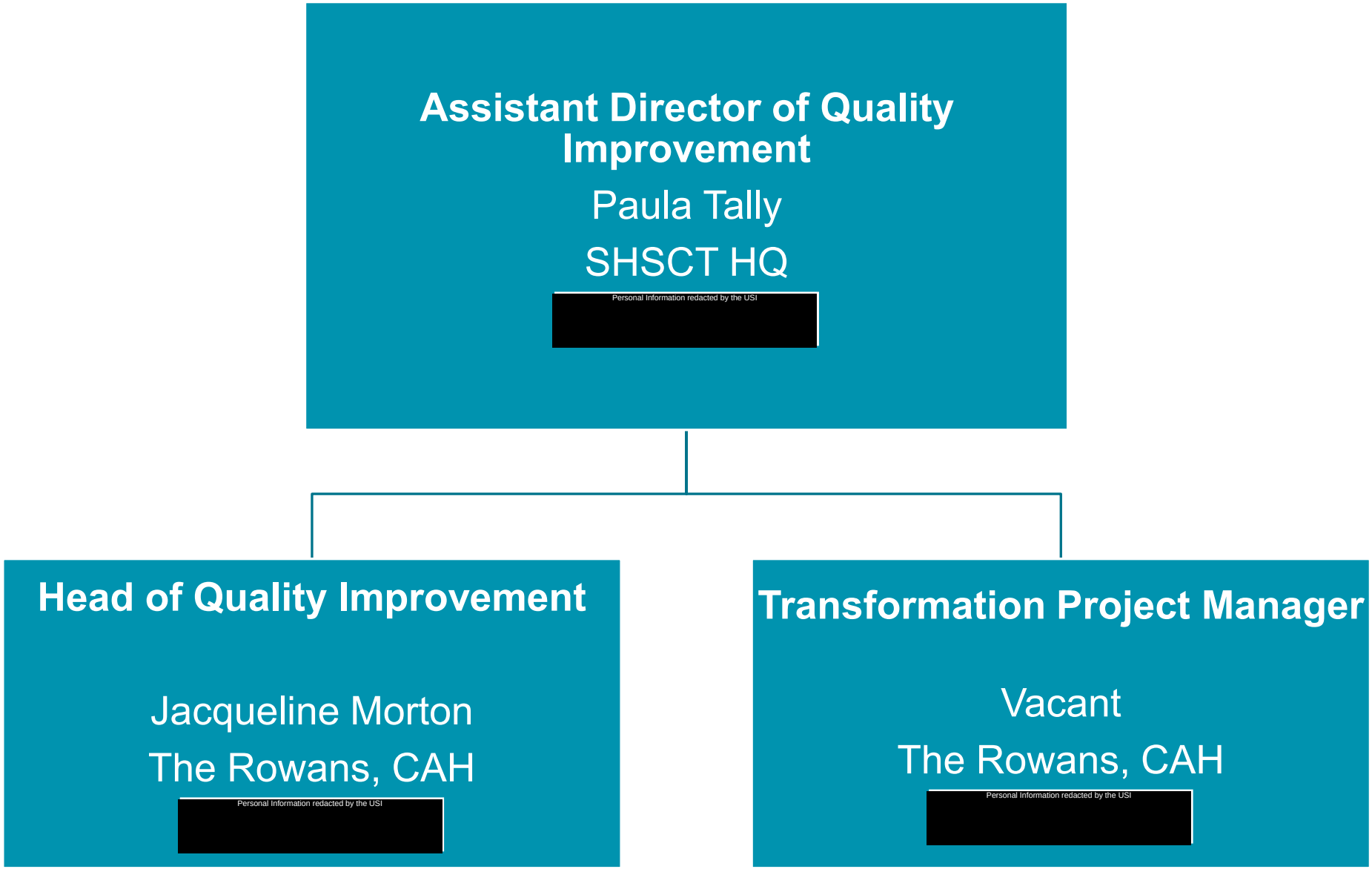
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Performance and Reform TRU-02106



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

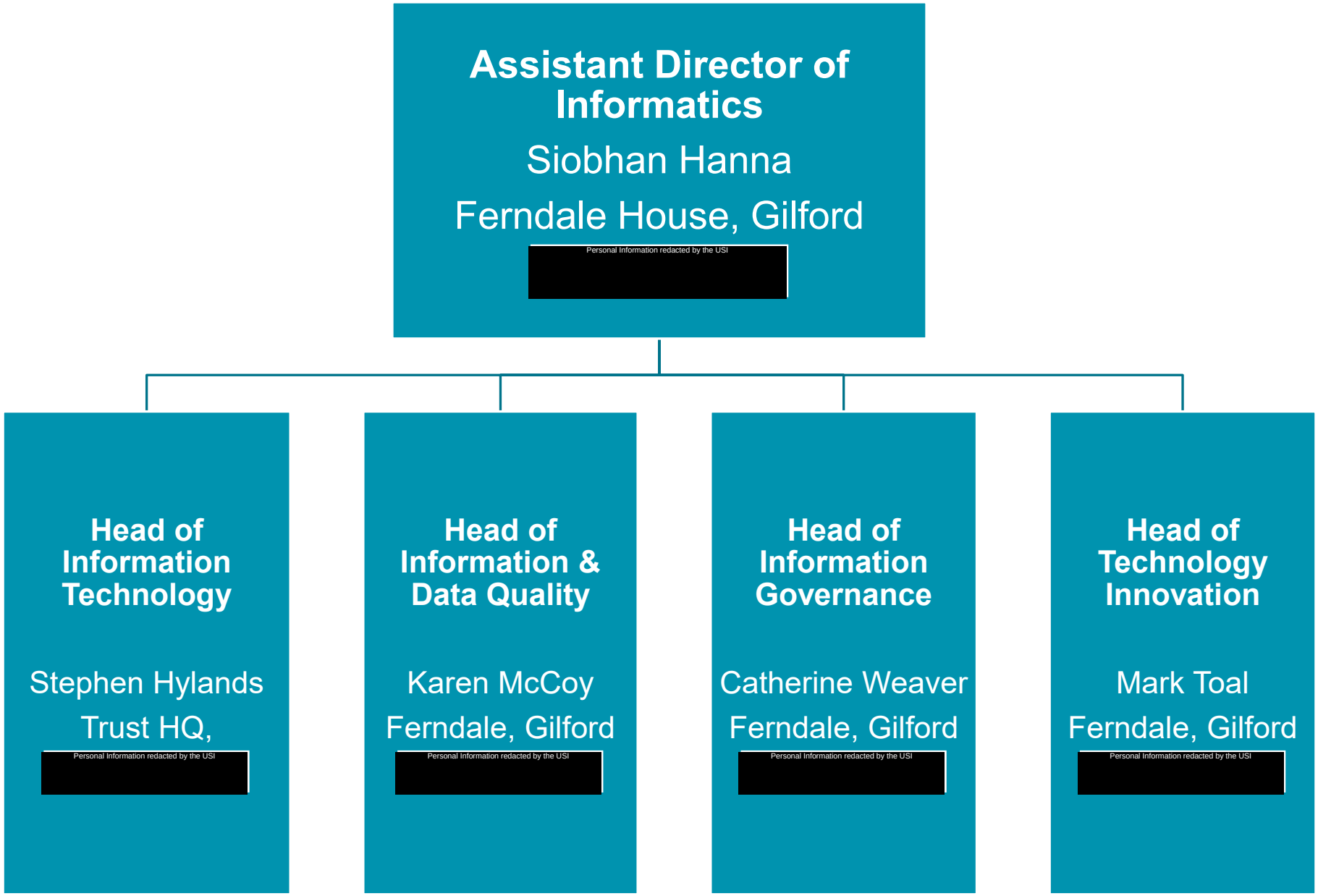
Directorate of Performance and Reform TRU-02107



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Performance and Reform

TRU-02108



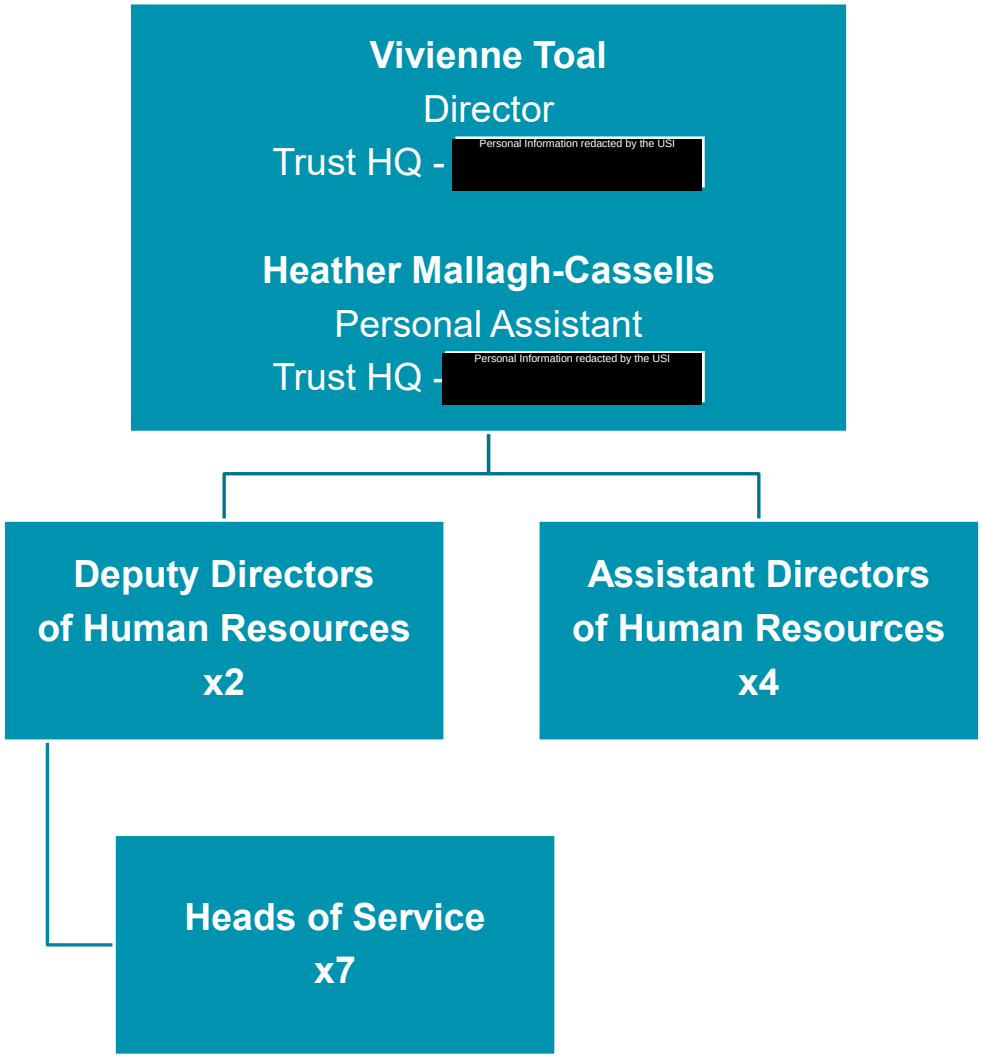
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Human Resources and Organisational Development

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

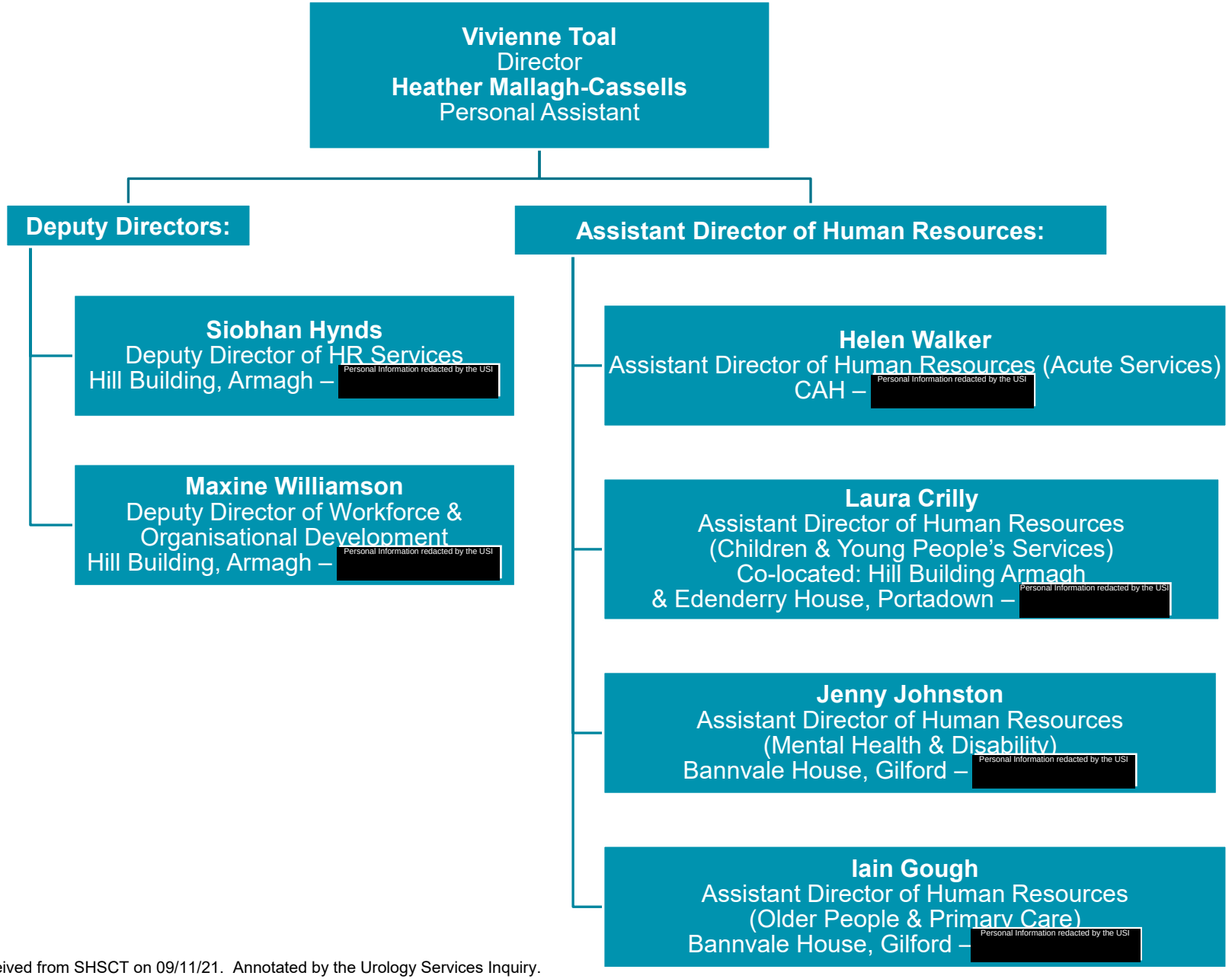
Directorate of Human Resources and Organisational Development

TRU-02110



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

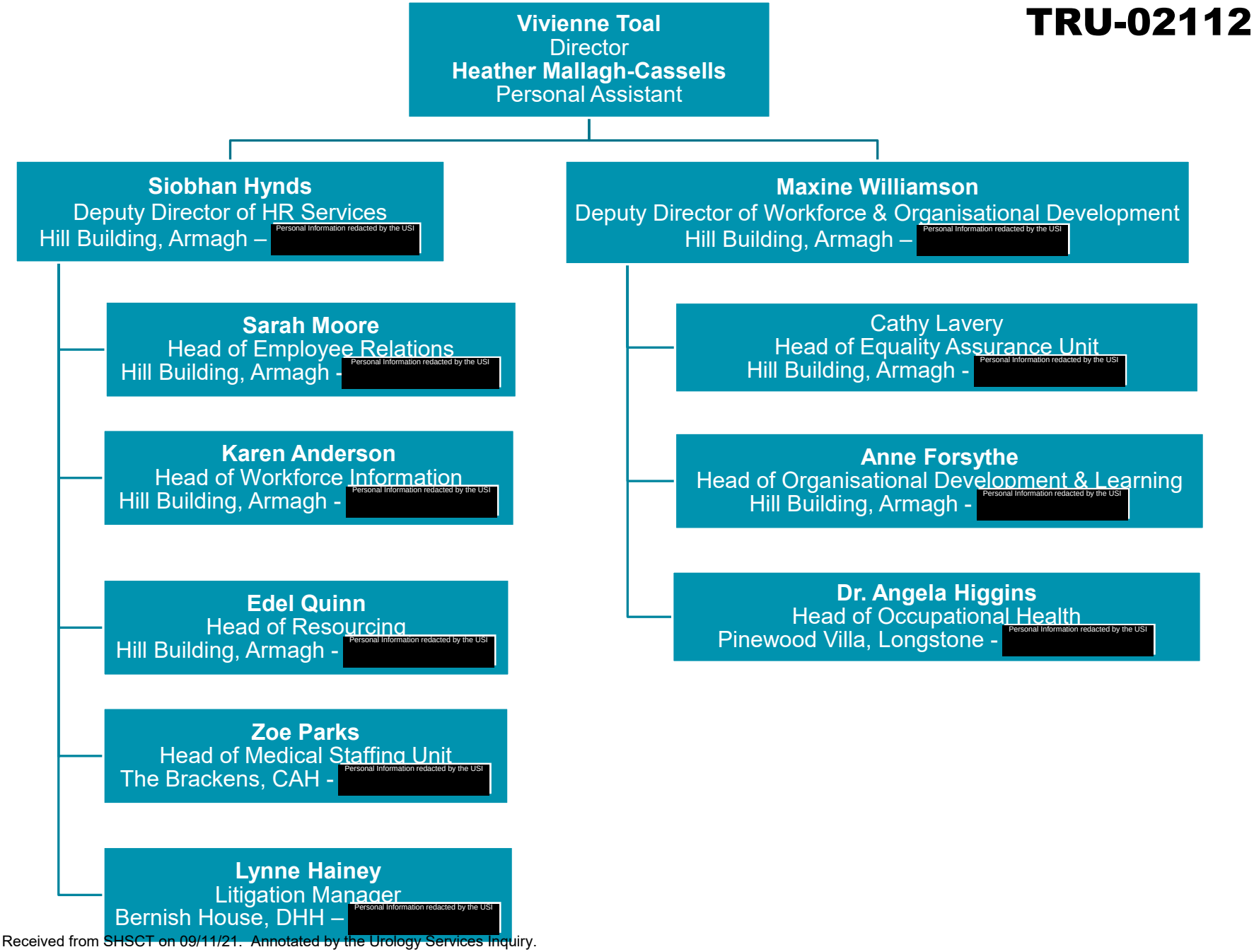
Directorate of Human Resources and Organisational Development



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Human Resources and Organisational Development

TRU-02112

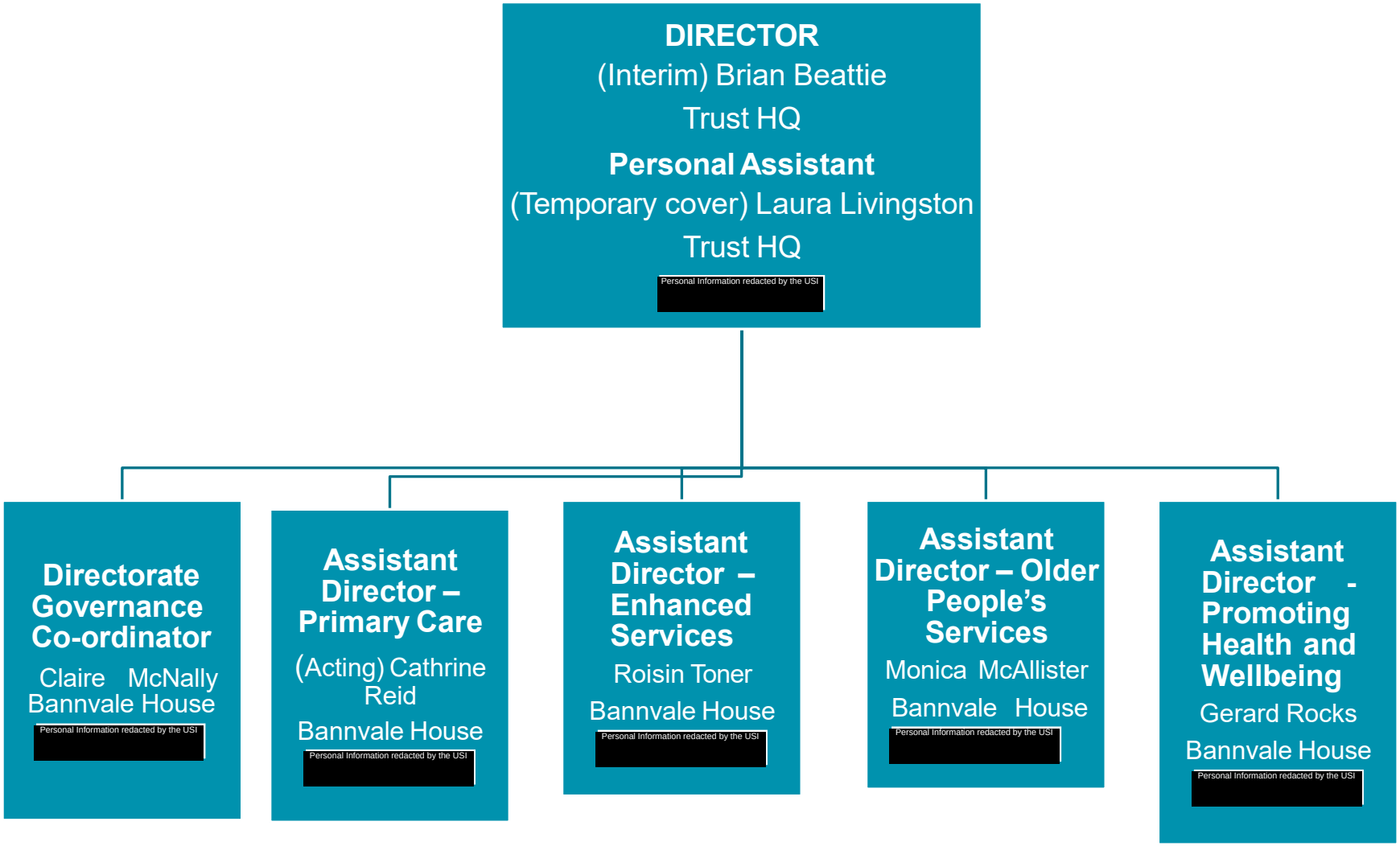


Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Directorate of Older People and Primary Care

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

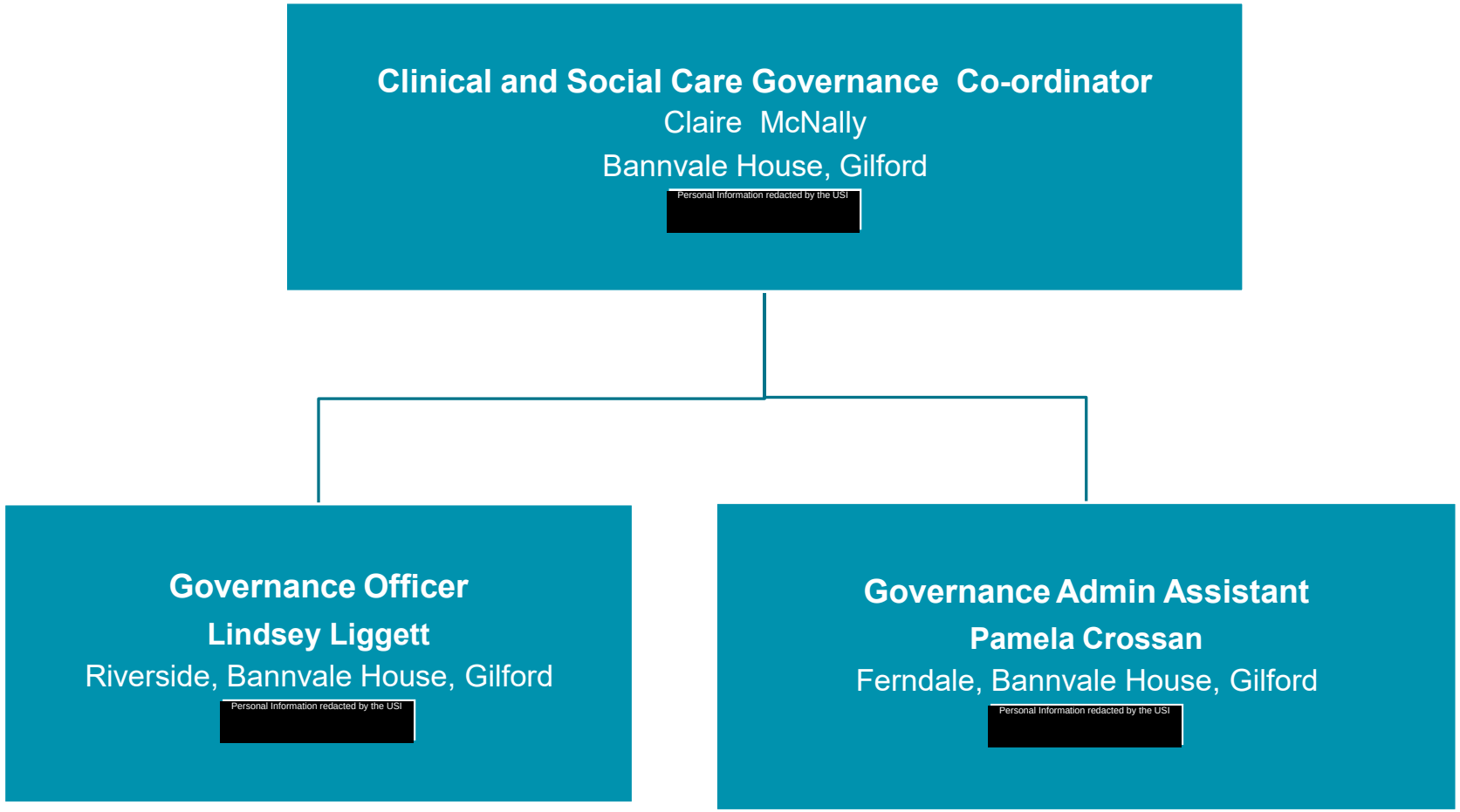
Directorate of Older People & Primary Care TRU-02114



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Clinical and Social Care Governance Team (OPPC)

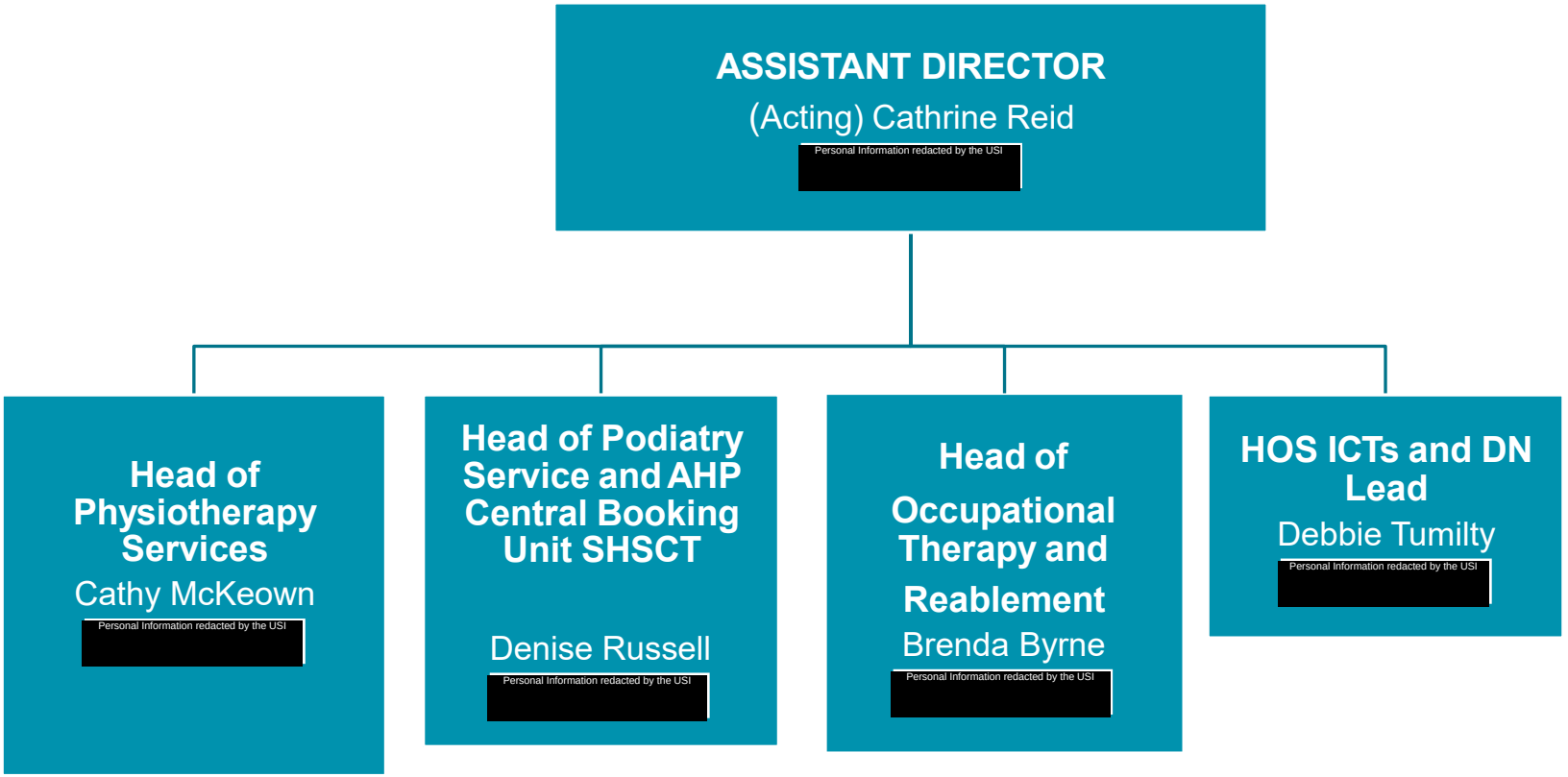
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Primary Care Division

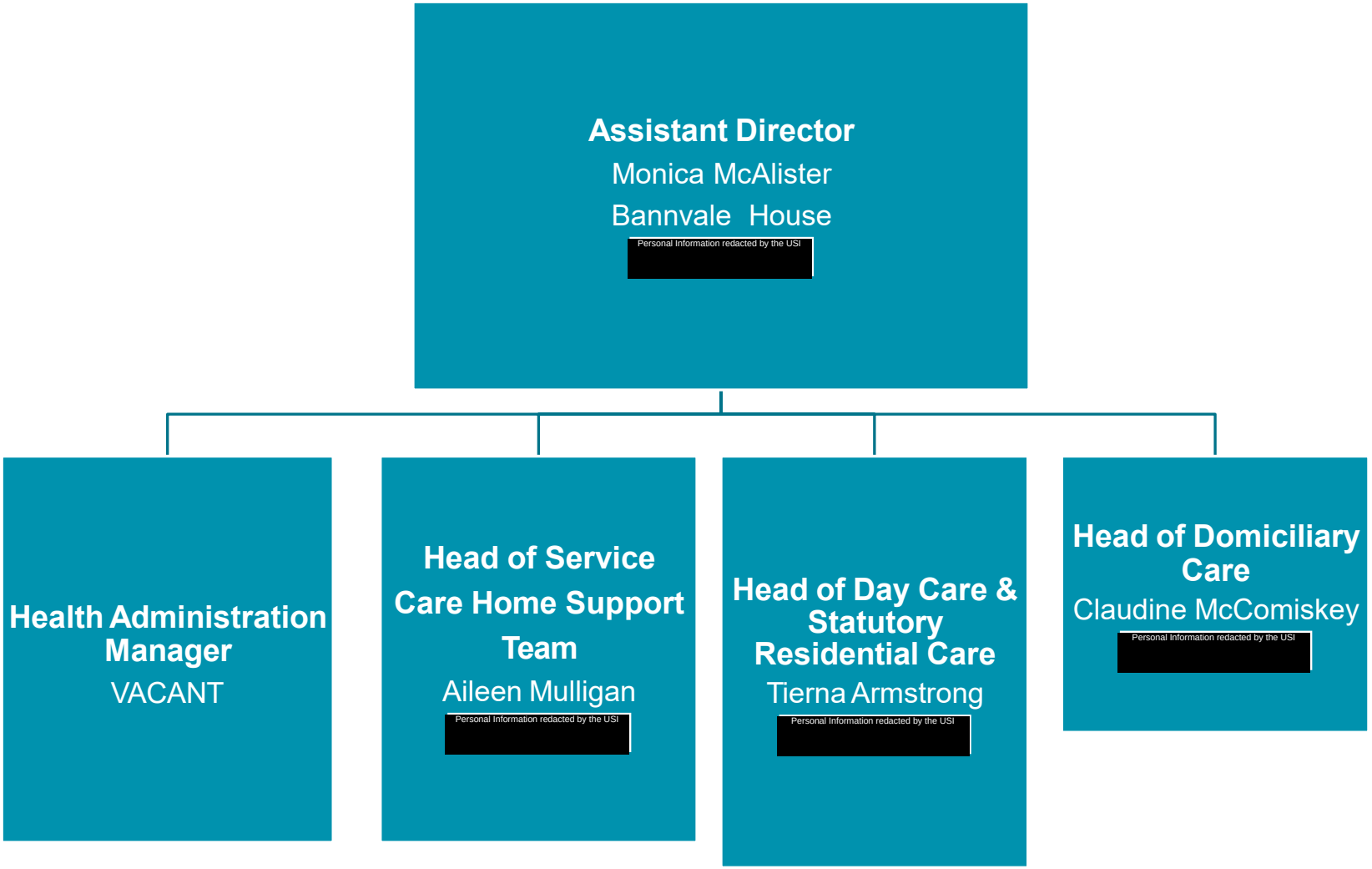
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Older Peoples Division

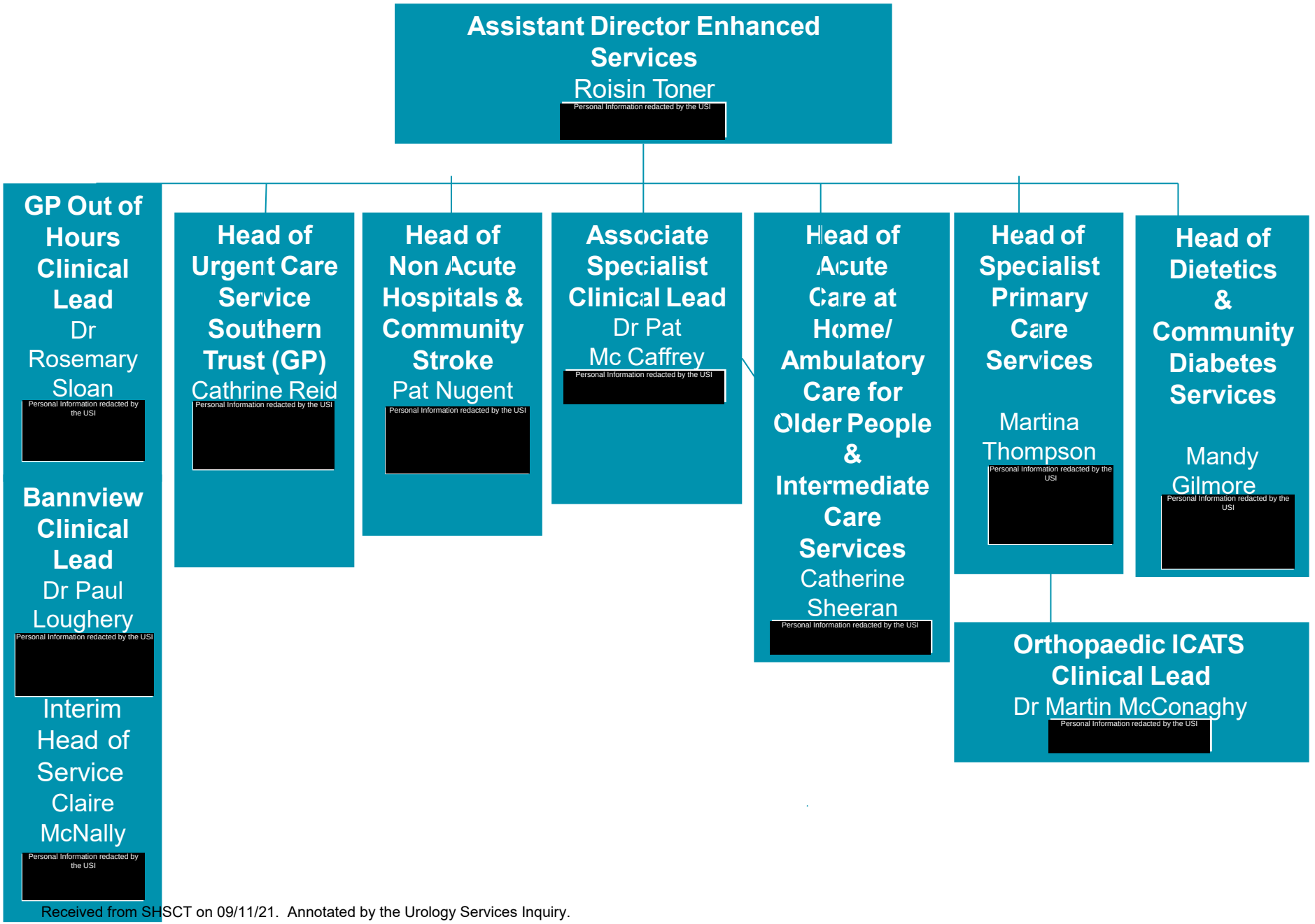
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Enhanced Care Division

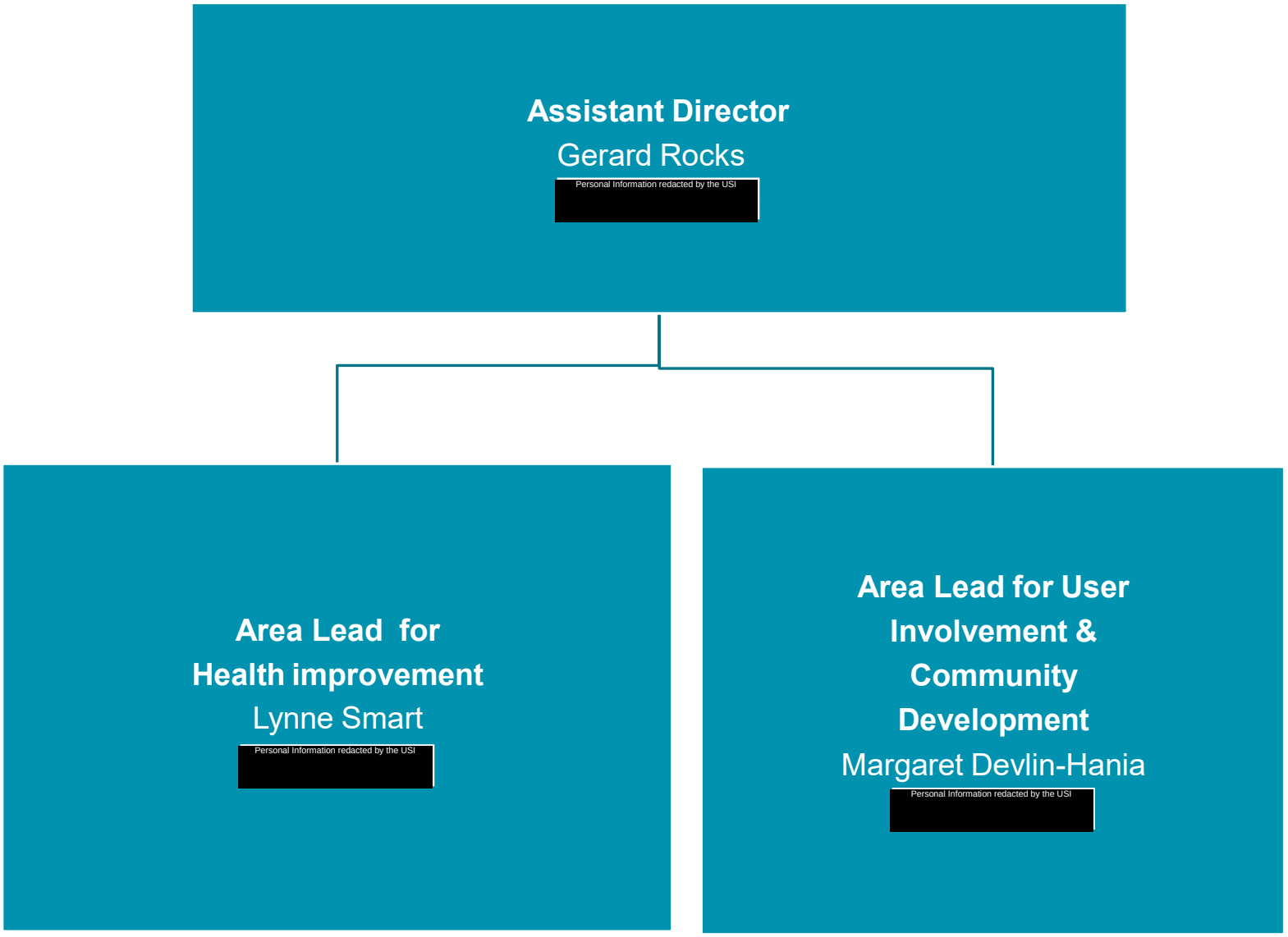
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Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Promoting Wellbeing

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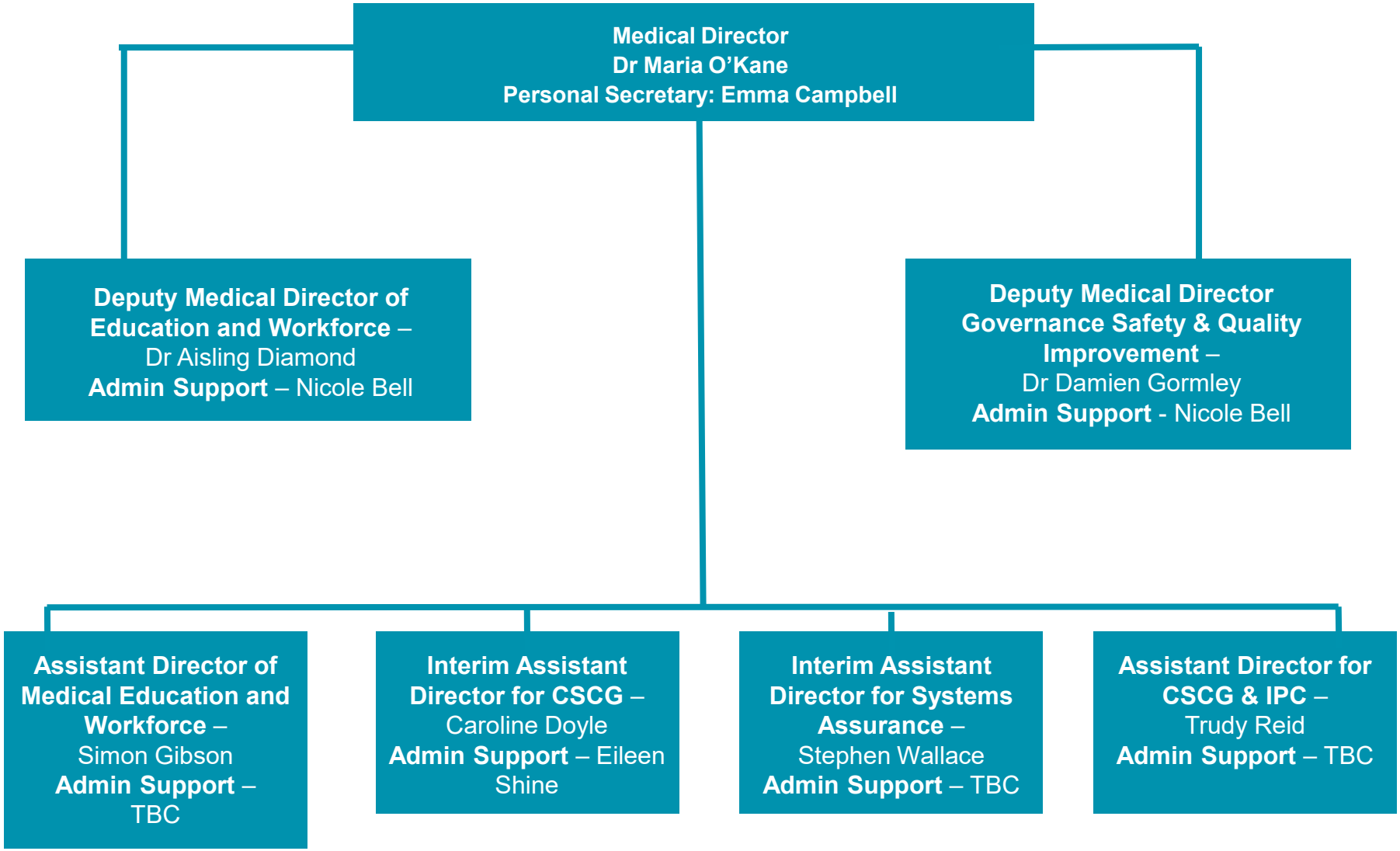
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Medical Directorate

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Medical Directorate

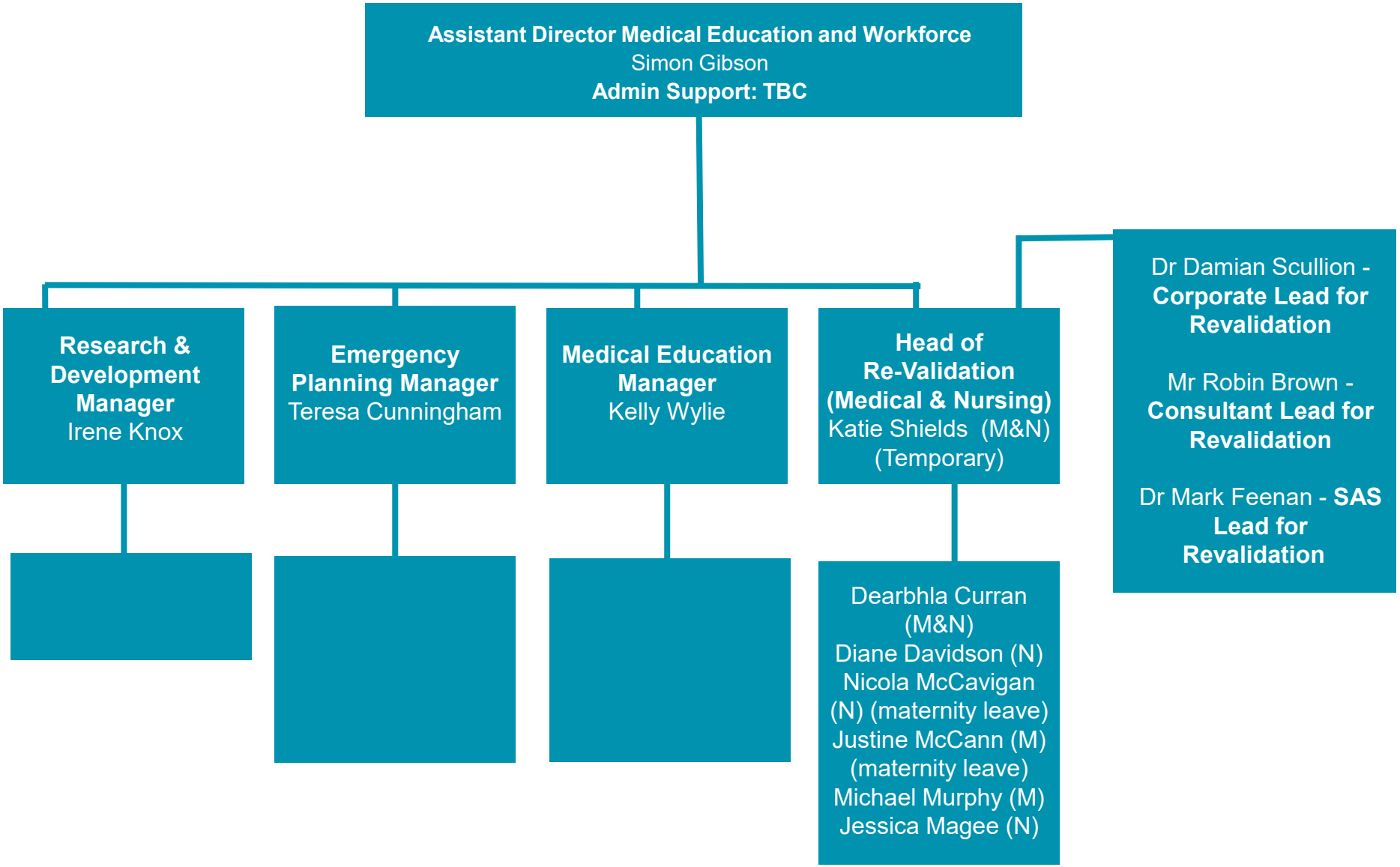
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Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Medical Directorate

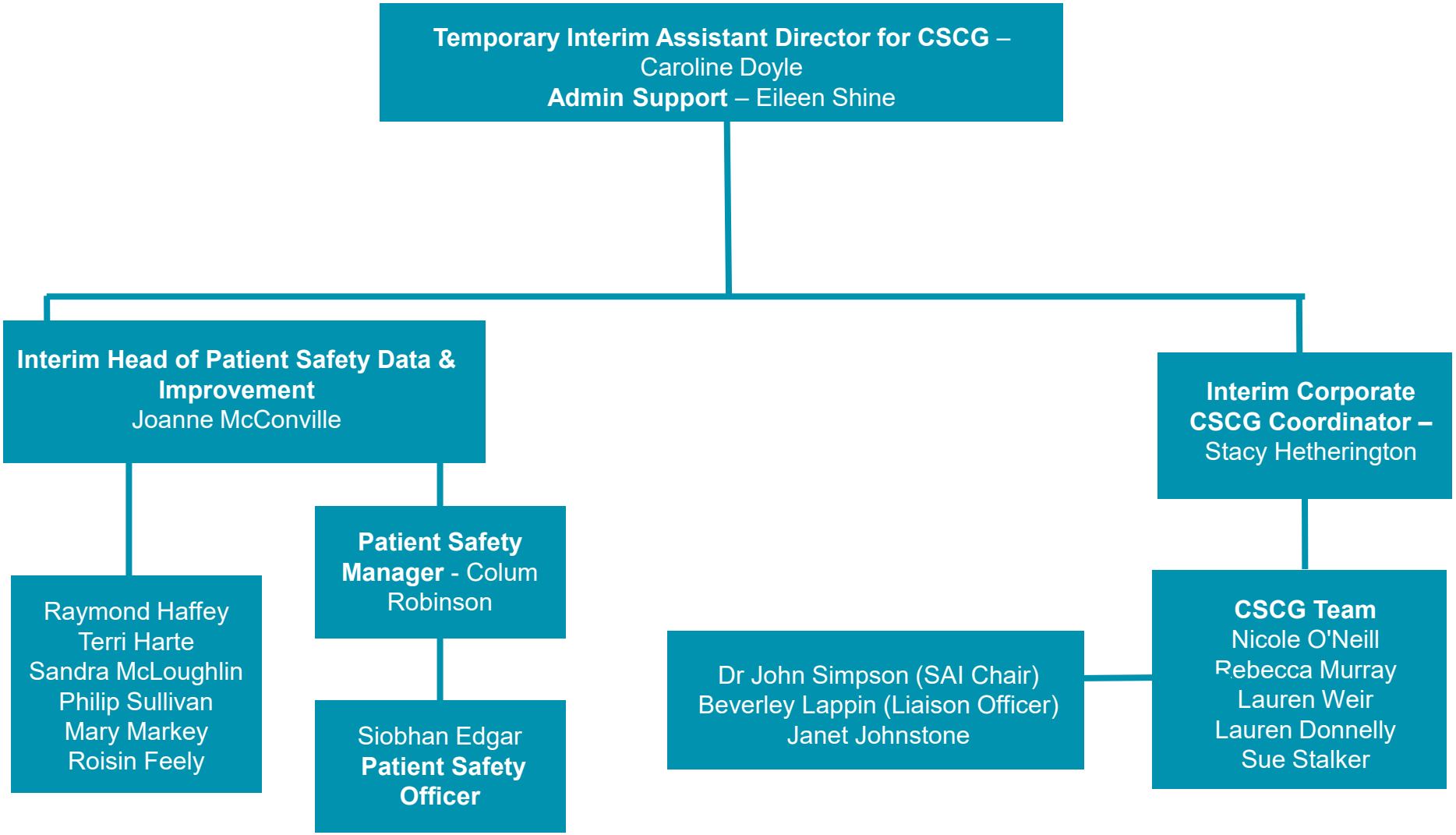
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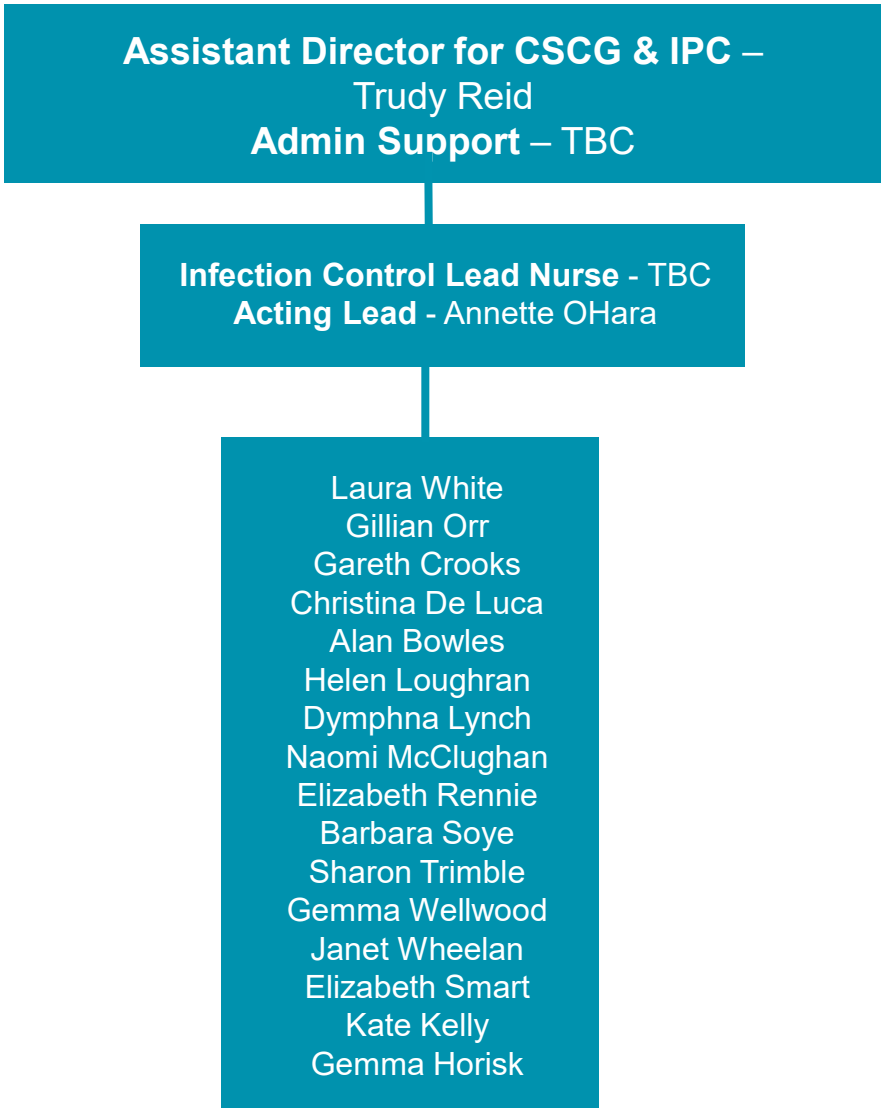
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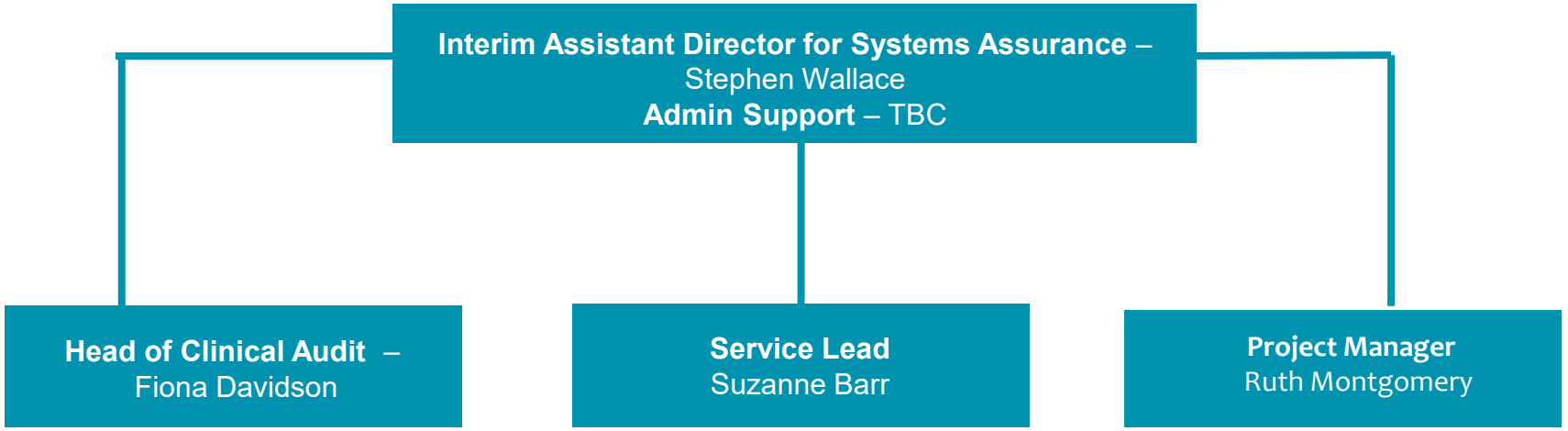
TRU-02124



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Medical Directorate

TRU-02125



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

INQ-20218

Parliamentary and Health Service Ombudsman

Broken trust: making patient safety more than just a promise

HC 1444

INQ-20219

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Presented to Parliament pursuant to Section 14(4)
of the Health Service Commissioners Act 1993

Ordered by the House of Commons
to be printed on 29 June 2023

HC 1444

Annotated by the Urology Services Inquiry



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This publication is available at https://www.gov.uk/government/publications

ISBN 978-1-5286-4244-6

E02931971 06/23

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

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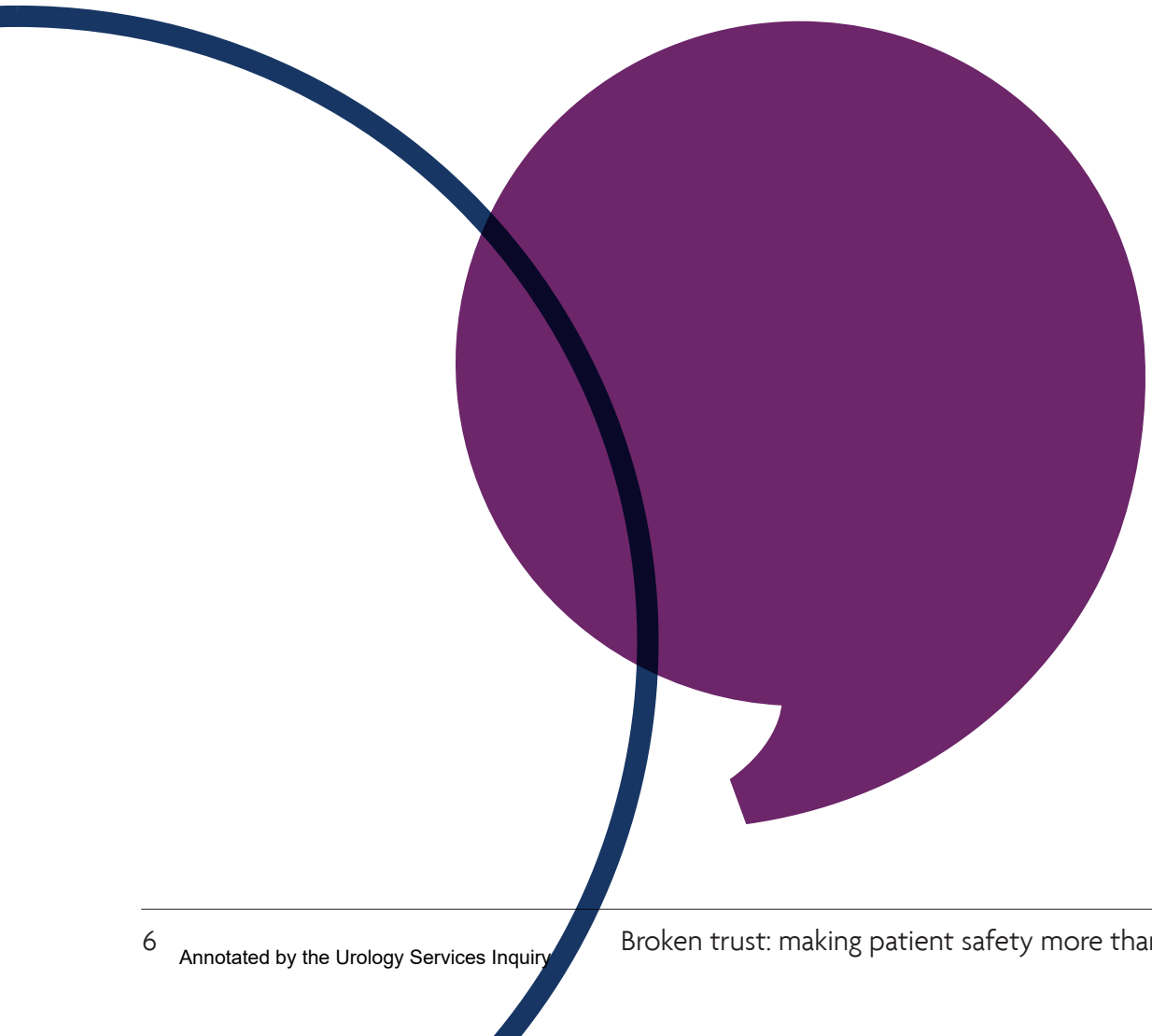
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About us

The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other public organisations.

When we investigate, we gather all relevant information from the person who made the complaint and the organisation they are complaining about. This will include relevant clinical records and information, such as a complaint file. We may get advice from experienced clinical professionals who are specialists in particular areas of care. We weigh up all the evidence impartially to reach a decision. In cases we uphold, we can make recommendations to put things right for the individuals involved.

We share insight from our casework to help improve public services and complaint handling. This includes highlighting failings in systems and failures to follow guidance if complaints show there is a need for further learning.



Foreword from the Ombudsman

'This must never happen again.' That phrase is uttered every time an NHS scandal hits the papers. But as we saw in the similarities between inquiries into maternity services in East Kent and Morecambe Bay seven years earlier, lessons are not always learned. It is as vital as ever that my Office continues to call for action to improve learning, accountability and, ultimately, safety.

The last ten years have seen significant activity from policymakers to improve patient safety. We have the NHS Patient Safety Strategy and welcome the introduction of the Patient Safety Incident Response Framework, which recognises the complexity of systems and the risks to staff and patients of a blame culture.

And yet, it is clear from the analysis of our most serious patient safety cases through this report that there is a gaping hole between best practice policy and consistent real-life practice. We may have a very sophisticated understanding of how to prevent patient safety incidents and avoid compounding harm for patients, families and staff when things do go wrong. But our evidence suggests that, on the ground, this is regrettably not always implemented.

Sadly, but perhaps inevitably, mistakes will happen in a complex health system that relies on human judgement. But every time my Office rules that a patient died in avoidable circumstances, it means that incident was not adequately investigated or acknowledged by the Trust. It also means staff, patients and their families had to go through an unacceptably long and painful process to make sure action was taken to address shortcomings and justice was achieved for the patient.

In this report, we consider the reasons for the continued failures to accept mistakes and take accountability for turning learning into action and improvement. We pose questions on how to embed an honest, open and unafraid culture in our healthcare system that supports staff and patients to challenge and learn.

Complex systems need robust regulation and oversight to recognise good practice and identify poor systems. When regulation and oversight work well, they also serve to keep people safe from harm. We need to see less fragmentation of the patient safety landscape. This report will have failed if it prompts the creation of yet another patient safety body or initiative. What we need is a streamlined system that works together, with real leadership from Government.

But the biggest threat to patient safety is a system at breaking point. In this report, we recognise that the NHS itself can only go so far in improving patient safety. We need to see concerted and sustained action from Government to make sure NHS leaders have the tools to prioritise the safety of patients and are accountable for doing so. This means getting past politics to put patient safety at the very top of the agenda.

Rob Behrens CBE
Parliamentary and Health Service Ombudsman

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Executive summary

There have been significant developments in patient safety over the last decade. But there is a concerning disconnect between increasing activity and progress made to embed a just and learning culture across the NHS. Recognising the challenging operational context for the NHS, this report draws on findings from our investigations. It asks what more must be done to close the gap between ambitious patient safety objectives and the reality of frontline practice.

We identified 22 NHS complaint investigations closed over the past three years where we found a death was – more likely than not – avoidable. We analysed these cases for common themes and conducted in-depth interviews with the families involved.

What we found

We found that the physical harm patients experienced was too often made worse by inadequate, defensive and insensitive responses from NHS organisations when concerns were raised.

When we looked at the direct causes of harm, we identified four broad themes of clinical failings leading to avoidable death:

- failure to make the right diagnosis
- delays in providing treatment
- poor handovers between clinicians
- failure to listen to the concerns of patients or their families.

We also looked at the further harm – sometimes called compounded harm – that happens when families, who have already experienced the devastating consequences of losing a loved one, try to understand what has happened but are met with a poor response from NHS organisations. We identified several factors that contribute to compounded harm:

- a failure to be honest when things go wrong
- a lack of support to navigate systems after an incident
- poor-quality investigations
- a failure to respond to complaints in a timely and compassionate way
- inadequate apologies
- unsatisfactory learning responses.

Our recommendations

Recognising the complexity of the issues identified, and the lack of easy solutions, our recommendations focus on two areas.

1. Accountability for a robust and compassionate response to harm, which supports learning for systems and healing for families

The Patient Safety Incident Response Framework (PSIRF) offers a new approach to patient safety investigations. It holds great promise but needs to be accompanied by sufficient monitoring and better support for families. We recommend that:

- Integrated care boards, with oversight from NHS England, should closely monitor the impact of the PSIRF to identify any negative consequences of the new flexibility it offers, which gives Trusts more autonomy to decide when a patient safety investigation is needed. This should include paying special attention to the balance of patient safety investigations versus other learning responses in Trusts (or service areas of a Trust) where there are poor Care Quality Commission (CQC) ratings for safety and leadership, or where other national bodies have raised concerns (recommendation 1).
- As part of their quality monitoring role, the PSIRF executive lead on each Board should look at any discrepancies between local and PHSO investigations, or other independent investigations, and make sure the Board discusses them. This should include where local investigations did not take place, or did not find that things went wrong, but PHSO or another independent oversight body later identified failings (recommendation 2).
- The Department of Health and Social Care and NHS England should further scrutinise the lack of compliance with duty of candour. They should review the operation of duty of candour to assess its effectiveness and make recommendations for improvement (recommendation 3).
- The Department of Health and Social Care should commit to funding further independent advocacy to support harmed patients, families and carers when they raise concerns or look for answers after an incident (recommendation 4).

2. Evidencing that patient safety is a top Government and NHS priority

NHS leaders and frontline staff need to be in no doubt of the priority placed on patient safety. But patient voice and leadership for patient safety are fractured. Political leaders have created a confusing landscape of organisations, often in knee-jerk reaction to patient safety crisis points. The Healthcare Safety Investigation Branch (HSIB), the Patient Safety Commissioner, PHSO, NHS England, NHS Resolution and at least a dozen different health and care regulators all play important roles in patient safety. But there are significant overlaps in functions, which create uncertainty about who is responsible for what. The Government must consider the case for streamlining some of these functions, for the benefit of people who use the NHS, their families and carers. This is not about reducing investment in patient safety. It is about creating a system that is coherent and easier to navigate, based on evidence and engagement with patients, families, NHS staff and leaders. We recommend that:

- The Department of Health and Social Care should commission an independent review of what an effective set of patient safety oversight bodies would look like. The review must include meaningful engagement with NHS leaders, staff, patients and families (recommendation 5).

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Patient safety must be a consistent priority over the long term. It must not be subject to changes of emphasis or importance each time there is a new minister or leadership change in the NHS. We recommend that:

- The Government should seek cross-party support for commitments to embedding patient safety and the culture and leadership needed to support it as a long-term priority (recommendation 6).

It is not possible to prioritise patient safety while avoiding difficult decisions about the workforce the NHS needs. Patient safety will always be at risk in environments that are understaffed and where staff are exhausted and under unsustainable pressure.

Tackling workforce shortages goes beyond political decisions about resourcing. It is about making the NHS a place where people want to work and stay because they feel valued, not just because it is a vocation. We must break down the false dichotomy between the interests of patients and staff, recognising that a system that does not treat its workforce with humanity and compassion will struggle to extend these qualities to patients and families.

We recognise the Government has promised to publish a new NHS workforce strategy. At the time of writing, this is expected 'shortly'. But for this to properly address the underlying causes of NHS staffing pressures, it needs cross-party consensus. In a sector where it can take nearly two decades to train a consultant doctor, a workforce strategy will only succeed if there is support from across the political spectrum, and far beyond one parliamentary term.

We recommend that:

- The Government should urgently produce its long-awaited long-term workforce strategy, with cross-party support, to increase the numbers entering and staying in the workforce across clinical and non-clinical roles. This strategy must:
    - include independent, evidence-based and fully costed projections of future workforce requirements
    - include detailed plans for training and recruiting new staff, retaining staff already working in the NHS and attracting those who have left to return
    - take account of the mix of different professional skills required, rather than just total numbers in the workforce, and how existing professional skills can be deployed where they are most needed (recommendation 7).

The Department of Health and Social Care should write to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication of this report to provide an update on progress against recommendations 3, 4, 5, 6 and 7.

NHS England should write to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication of this report to provide an update on progress against recommendations 1 and 3.

Introduction

It is ten years since the landmark Francis Inquiry into failings of care at Mid Staffordshire NHS Foundation Trust. The final report identified a system that should have picked up on appalling deficiencies in quality and safety of care, but 'failed in its primary duty to protect patients and maintain confidence in the healthcare system'.[1] The report also argued that a fundamental culture shift was needed, to make sure 'the patient is put first day in and day out.'[2]

The Francis report was a wake-up call for healthcare systems. In the decade that followed, the patient safety landscape has undergone significant change. Globally, there has been greater recognition of the importance of safety science in healthcare and a strategic approach to patient safety. In 2020, patient safety was included as one of the five priorities of G20 Health Ministers, and 2021 saw the publication of the World Health Organisation Global Patient Safety Action Plan.

The NHS developed an NHS Patient Safety Strategy in 2019, with an updated version expected this year. The strategy has a vision to save 1,000 lives and £100 million per year and has seen some concrete successes in specific areas, such as improved care of premature babies and reductions in prescribing opioids (pain-relieving medicines that have a serious risk of addiction).[3] This year, the NHS will roll out the Patient Safety Incident Response Framework (PSIRF), marking a major change in the approach to recording and learning from patient safety incidents. There are also plans to expand the roll-out of medical examiners to provide independent scrutiny of the causes of deaths. This should provide answers for bereaved relatives and help NHS organisations to learn and improve the care of future patients.

On issues of transparency, there is now a legal duty of candour requiring organisations to be honest with families when they make mistakes. And there are freedom to speak up guardians to give staff a route to report patient safety issues in each hospital. There is greater recognition of the insights that patients, families and carers hold, with a Patient Safety Partner role set up to use these insights in managing patient safety.

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[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary (February 2013).

[2] As above.

[3] Statistics on impact shared with us by the Patient Safety Strategy team. Improved care of premature babies through optimal cord management (delaying cutting the cord after a baby is born) has saved up to 417 lives since 2020. There have been up to 347 lives saved over two years and 2,152 fewer cases of short-term harm each year, as a result of fewer people with chronic pain being prescribed long-term opioid pain relief compared to 2021. (Figures calculated in March 2023.)

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Following the recommendation of the Independent Medicines and Medical Devices Safety Review, the role of Patient Safety Commissioner has been created to amplify the views of patients in relation to medicines and medical devices.

There has also been an important transition to a more widespread understanding of patient safety as a systems issue. As the NHS Patient Safety Strategy recognises, failings in care often result from systems and processes that allow errors to happen, rather than from people who lack the skills to care, or who deliberately cause harm. The national conversation around patient safety now focuses on learning, rather than seeking to blame individuals. And it recognises the huge complexity in healthcare processes, which means to understand when things go wrong, we must look at all the environmental and organisational factors that affect behaviour at work, not just the specific incident. This approach is now supported by the work of HSIB, drawing out national safety recommendations from its investigations.[4]

It is clear there is no shortage of programmes, policies, new initiatives and roles to try to reduce instances of avoidable harm. But there is a disconnect between the increasing levels of activity and consciousness about patient safety and the level of progress we see on the frontline. The statistics about patient harm remain stark. There are an estimated 11,000 avoidable deaths every year in the NHS due to patient safety failings, with thousands more patients seriously harmed.[5] Behind these numbers are the stories of individuals and their families and friends, whose lives have been shattered as a result of avoidable harm.

There is a well-recognised 'implementation gap' – the difference between what we know improves patient safety and what is done in practice.[6] Overcoming this represents a huge challenge. The NHS is an incredibly complex and sometimes fragmented system, making it challenging to embed changes to working practices and cultures. The structural changes brought in by the 2022 Health and Care Act offer the potential for better collaboration at a regional and local level through Integrated Care Systems and place-based partnerships. But such structural change brings the risk of disruption as local leaders divert attention to building new organisations and relationships. There is also good reason to be concerned about the prospects for reducing avoidable harm when attention is focused overwhelmingly on throughput, and the people and systems that make up the NHS are under growing pressure.

We know there is a long way to go to embed working cultures that can learn and improve in response to failings in some parts of the NHS. In the latest NHS Staff Survey, nearly 40% reported they did not feel safe to speak up about anything that concerns them in their organisation. More worrying still, less than half of staff felt confident their organisation would address their concern.[7]

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[4] From October 2023, HSIB will become the Health Services Safety Investigations Body (HSSIB), an independent public body under the Health and Care Act 2022, with its own 'safe space' for confidential investigations. The CQC will host HSIB's maternity programme.

[5] NHS England and NHS Improvement (July 2019), 'The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients'.

[6] Patient Safety Learning (April 2022), 'Mind the implementation gap: the persistence of avoidable harm in the NHS'.

[7] NHS Staff Survey 2022: National results briefing, March 2023.

In clinical safety specifically, more than a quarter of staff did not feel secure raising concerns about unsafe clinical practice and nearly 40% did not feel confident their organisation would address their concern about unsafe practices. These two measures have worsened in the last two years.[8] This polling is a reminder of the gap between the 'learning not blaming' vision of national strategies and the day-to-day experience of frontline NHS professionals.

Concerns about progress in patient safety need to be considered against a backdrop of intensifying workforce pressures, creating further risks. Latest data from NHS England shows there are more than 8,000 doctor vacancies and more than 40,000 nursing vacancies across the NHS.[9] The CQC, in its latest State of Care report, said that 'continuing understaffing in the NHS poses a serious risk to staff and patient safety, both for routine and emergency care'.[10]

The latest data from the British Social Attitudes Survey shows the cracks are growing. Although the British public remain committed to the founding principles of the NHS as a universal service, funded by taxation and provided free at the point of contact, public satisfaction with the service is now at just 29%. This is seven percentage points lower than the year before and the lowest level since the survey began in 1983.[11]

The NHS cannot wait any longer. Nor can the people who use it or work in it. We must see urgent action and sustained commitment to address the root causes of problems that result in patient harm.

About this report

Recognising this challenging context, we have developed this report to share learning from our investigations into complaints about serious avoidable harm in the NHS.

Our intention is not to further demoralise NHS staff and leaders at a time of extreme pressure. We recognise that the vast majority of NHS staff are highly motivated to provide excellent care and never intend to cause harm. And we know that involvement in patient safety incidents can be traumatic for staff too.[12]

The Ombudsman has a unique position in the patient safety landscape. We investigate impartially and do not take sides or speak on behalf of patients or clinicians. Our role is to objectively and independently understand what happened. Where we find failings, we make recommendations for learning to improve services and protect patients. The cases we see highlight persistent clinical failings and, perhaps even more importantly, persistent failure to respond to patients and families in a compassionate way when they raise complaints.

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[8] NHS Staff Survey 2022: National results briefing, March 2023.

[9] NHS Vacancy Statistics, England, April 2015 - December 2022, Experimental Statistics.

[10] CQC (October 2022), State of Care 2022, Summary.

[11] The Kings Fund (March 2023), Public satisfaction with the NHS.

[12] See, for example, research outlined in BMJ (2015), 'Supporting "second victims" is a system-wide responsibility'.

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This report builds on the detailed and extensive work of countless others over the past ten years. In recognition of that, we have engaged with policymakers, oversight bodies, regulators, professional bodies and advocacy organisations to test and refine our conclusions and recommendations.

By analysing the unique evidence of complaints we have investigated, we have identified two sets of findings. First, we reflect on common themes that emerge when clinical failings have led to avoidable harm. Despite the diversity in the cases we looked at – some involving babies a few days old, others older adult patients; situations that progressed in a matter of hours and others over a number of years – there are issues that come up repeatedly.

Second, we look at the additional harm – sometimes called compounded harm – that happens when families, who have already experienced the devastating consequences of avoidable harm, try to understand what has happened to their loved ones but are met with a poor response from NHS organisations.

In the final section, we suggest the wider changes needed to see the improvements that patients, families and clinicians deserve when it comes to serious avoidable harm.

How we developed this report

To develop this report, we undertook a qualitative analysis of over 400 detailed health complaint investigations from the past three years. We identified 22 cases where someone had died and we found that the death was – more likely than not – avoidable. We know that relatively few families, having been through a local complaints process while dealing with their own grief, will feel able to keep going and bring their case to us. So these 22 cases are a significant sample of what is likely to be a much bigger problem.

In these cases, we found that the patients would not have died if they had received the right care and treatment at the right time. This happened mainly in inpatient settings in NHS acute trusts, including emergency departments, intensive care units (ICUs) and general medical wards.

We analysed the cases in more detail to develop the themes in this report. We conducted four interviews with families who brought the cases to us, to hear from them directly about their experience of raising concerns with Trusts. We supplemented this with a review of secondary literature on patient safety to put our evidence in context.

Words we use in this report

Throughout this report, we use **clinical failings** to refer to clinical care and treatment that a patient should have received but did not receive.

We use **avoidable harm** to refer to clinical harm that a patient suffers because they did not receive the right care and treatment at the right time.

Our casework evidence on avoidable harm

Clinical failings leading to avoidable harm

Patient harm is a global phenomenon[13] that happens everywhere patient care takes place. Over 1.25 million staff in the NHS[14] have 1.5 million patient interactions every day,[15] so it is inevitable that mistakes will happen. But, despite improvements over the last ten years, the estimated number of 11,000 avoidable deaths every year is shocking.

After analysing the 22 cases where we found that a death was avoidable, we identified four broad themes of clinical failings leading to avoidable harm:

- failure to make the right diagnosis
- delays in providing treatment
- poor handovers between clinicians
- failure to listen to the concerns of patients or their families.

Failure to make the right diagnosis

In more than half of the cases we looked at, we found that a failure to diagnose directly led to or significantly contributed to the avoidable death of a patient. In these cases, the right diagnosis could have been made at the right time. If this had happened and the correct treatment had been provided, it is likely the patient would not have died.

A range of factors and circumstances can lead to clinicians not making the right diagnosis at the right time, especially when a patient's condition is complex or critical. In our casework analysis, failures to make the right diagnosis were mainly the result of:

- not seeking more senior or specialist input where that would be appropriate
- not observing or monitoring someone at regular enough intervals to recognise deteriorating health or new issues
- failings in imaging, such as failing to follow up on an unexpected finding.[16]

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[13] Bennett, S. A. (2020), 'Avoidable deaths in Britain's National Health Service - A systems-thinking informed analysis using data garnered from government agencies, representative bodies, private canvassing and public inquiries'. International Journal of Healthcare Technology and Management, 18 (1–2), pp. 95–110.

[14] NHS Workforce Statistics - December 2022.

[15] The King's Fund (October 2022), Activity in the NHS.

[16] For a more detailed analysis of failings in imaging, see our 2021 report, 'Unlocking Solutions in Imaging: working together to learn from failings in the NHS'.

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In one case we looked at, the patient's National Early Warning Score (NEWS score)[17] showed he was very unwell and should have been reviewed by a more senior clinician with the knowledge and experience to diagnose and treat him while his condition was getting worse. The Trust should have asked for an urgent review by a more senior clinician, but this did not happen. When the patient's condition got worse, the Trust delayed asking for an urgent review, and there were further delays in reviewing the patient. This meant the Trust failed to recognise the patient had sepsis and did not give him the right treatment. The patient suffered a cardiac arrest (when the heart stops pumping blood around the body) and died.

We identified the importance of appropriate and timely senior input in our report on sepsis, 'Time to Act', noting that 'the skills necessary for early identification of patients at risk of severe sepsis are high level and develop with long experience'.[18] It is concerning that a decade after this report, and following huge efforts to improve the early recognition and treatment of sepsis, we still see these kinds of failings.

[17] NEWS is the National Early Warning Score designed to standardise the assessment of and response to acute illness. It combines scores along six physiological measures: respiration rate, oxygen level, blood pressure, pulse rate, level of consciousness or new confusion and temperature. It was updated in 2017 and NEWS2 is endorsed by NHS England as the early warning system for use in all secondary care and ambulance services.

[18] PHSO (2013), 'Time to Act', p. 43.

Case study: failure to diagnose pulmonary embolism

- A man contacted an out-of-hours GP service because he had been suffering from shortness of breath for over a month and had a fever. The GP diagnosed a chest infection and prescribed steroid medication.
- The patient's family called for an ambulance the same evening because his breathlessness had started to get worse. The ambulance crew arrived and took him to hospital.
- The patient's observations showed a fast heart rate, raised rate of breathing and a low level of oxygen in his blood. Staff gave him a nebuliser and his oxygen levels improved.
- A doctor reviewed the patient. An X-ray did not show any concerns. The doctor diagnosed pneumonia, prescribed antibiotics and decided not to admit the patient.
- The following day, a GP visited the patient at home and prescribed an inhaler. They suggested the patient should return to the hospital.
- Later that day, the patient's family called an ambulance because they were concerned about his condition. When the ambulance arrived, the patient was conscious but short of breath.
- The patient suffered a cardiac arrest and the paramedics tried to resuscitate him. Unfortunately, they could not do so and the patient died. The cause of death was a pulmonary embolism (a blocked blood vessel in the lungs).
- We found the doctors failed to follow the relevant guidance when they reviewed the patient at the hospital.
- The clinical signs the patient presented suggested a pulmonary embolism was the likely cause of their breathlessness, high heart rate, high respiratory rate and low oxygen. Doctors should have arranged a specific blood test, but this did not happen. Instead, the patient was sent home without the right treatment.
- The doctors made a diagnosis of pneumonia (inflammation of the lungs) but the chest X-ray results showed the patient's lungs were clear and there was no evidence of blood tests to confirm a diagnosis of infection.
- We found it likely the patient would have survived had he received the right treatment after the doctor reviewed him. This would likely have led to the diagnosis of pulmonary embolism and successful treatment with the right medication.[19]

[19] In its report on the diagnosis of pulmonary embolism in emergency departments, HSIB identified a safety risk in missed diagnosis and treatment of pulmonary embolism, given its atypical symptoms: HSIB (2022), 'Clinical decision making: diagnosis of pulmonary embolism in emergency departments'.

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We spoke to the patient's mother who described her and her family's experience of seeing the patient die at home:

'My son came home with absolutely no information whatsoever ... He should have been in hospital, he should have been on a ward. He died in his bedroom and I had to hear it ... My grandson was in the room next door with me and he heard him die too. It's not something that you would want for anybody.'

Failing to observe or monitor someone at regular enough intervals can result in missed opportunities to recognise deteriorating health or new issues. In one case we looked at, a man was admitted to the Trust's emergency department with chest pains. His condition got worse in hospital but staff did not carry out observations to monitor him as frequently as they should have done. This resulted in a missed opportunity to notice the patient's health getting worse due to sepsis and to involve critical care. It delayed the diagnosis and treatment of sepsis for over ten hours. We found that if the patient had been monitored at appropriate intervals, it is likely his worsening health would have been identified, he would have received treatment for sepsis and, more likely than not, he would have survived.

In another case, a mental health Trust did not observe a long-term inpatient as frequently and as closely as it should have done. The woman attempted to harm herself in a way that could have led to her death on two occasions. Staff managed to stop her from harming herself both times. The Trust should have updated the risk assessment to include actions to reduce any risks and minimise harm, including risks posed by ligature points (anything that could be used to attach a cord, rope or other material for the purpose of self-harm). The following day, the patient was found unresponsive and died because of a hypoxic brain injury (when the brain does not get enough oxygen). We found that if the Trust had observed the patient more closely and frequently and taken action to address ligature points, it was unlikely the suicide attempt would have been completed. If the patient had been monitored more frequently, it is likely there would have been the opportunity to intervene in time and prevent the woman's death.

We spoke with the patient's sister who told us the Trust did not manage to keep her sister safe:

> 'It was supposed to be a place of safety and it clearly wasn't. My sister shouldn't have died in the hospital.'

Case study: failure to carry out repeat risk assessments

- A patient went to a Trust's emergency department with a swollen left hand. The patient had cellulitis (a bacterial skin infection that causes swelling) and gout (a build-up of uric acid causing swelling in the joints).
- The Trust admitted the patient to the hospital and considered their risk of developing venous thromboembolism (VTE, a condition that happens when a blood clot forms in a vein).
- The Trust decided there was no risk and did not carry out any further risk assessments. Staff treated the patient, which included elevating their arm and giving them antibiotics.
- A couple of days later, the patient started experiencing chest pains and tightness in their chest. The Trust carried out an electrocardiogram (ECG, a test to check the heart's rhythm and electrical activity) and provided medication. Later that day, the patient became sick and collapsed.

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- The doctor planned to move the patient to a bed with more monitoring. But, before this could happen, the patient suffered a cardiac arrest. The Trust resuscitated the patient and gave them medication to break down blood clots.
- After this, the patient remained stable for a short time during which they were moved to the intensive care unit. Sadly, their condition did not improve and they died that evening. The Trust carried out an autopsy which confirmed the cause of death as a pulmonary embolism (blockage of a lung artery).
- We found the Trust failed to carry out a full assessment of the patient's risk of developing VTE, and then failed to reassess them 24 hours later as outlined in NICE guidance. It missed two opportunities to provide appropriate and timely treatment to prevent a pulmonary embolism.
- Had the Trust given the right treatment on time, it is more likely it could have prevented the pulmonary embolism and avoided the patient's death.

Delays in the treatment response

Our casework shows that serious harm can be caused by delays in providing treatment. In our analysis, we found that these delays often relate to:

- a diagnosis being made but then not being acted on properly or quickly enough
- not acting quickly enough on observations.

In one of the complaints we looked at, the Trust appropriately and quickly diagnosed a woman with vasculitis (inflammation of the blood vessels). Vasculitis is a condition that needs urgent treatment. But the Trust did not prescribe the medication needed for another 16 hours after the diagnosis. After prescribing the medication, the Trust did not give it to the patient for another 11 hours. The Trust significantly delayed giving the patient the life-saving treatment she needed for 27 hours. Our investigation found the patient could have survived if she been given the correct medication in time. It is more likely than not that her death could have been avoided.

When there is evidence that a patient's health is getting worse it is vital to respond quickly, but we found instances where this did not happen. For example, in a case where the on-call doctor did not attend when requested to, we found that the way they were contacted (via a 'bleep') did not include information about the urgency of the request. The Trust explained the system does not give any sign of urgency unless the doctor is being called to attend a cardiac arrest. Our investigation report highlighted that this is a problematic system because it does not allow clinicians to prioritise their patients' needs. We argued that it undermines the benefits of a warning system like NEWS if clinicians are not meaningfully empowered to act quickly in response.

This is a well-known issue. It is highlighted, for example, in a recent national investigation report by HSIB on recognising and responding to critically unwell patients. The report notes that early warning scores 'can place a high demand on medical staff and the current escalation protocols may not be achievable owing to a task versus resource mismatch'.[20] Clearly, monitoring is only useful if there are enough staff to respond when deterioration is detected.

Case study: failure to provide timely sepsis treatment

- A patient went to hospital for a hysteroscopy (a procedure to examine the inside of the womb).
- The procedure was completed without incident and the plan was for her to stay in hospital to be monitored.
- After being transferred to the ward, she felt unwell. Staff carried out assessments to examine her symptoms. The results showed abnormal blood tests, including a very low white blood cell count.
- The patient was referred to and reviewed by the emergency medical response team. The doctors considered sepsis as one of several possibilities for explaining the clinical findings. But they thought this was unlikely so they did not prescribe antibiotics.
- The patient was transferred to the acute medical unit for closer monitoring. The doctor who reviewed her recommended an immediate dose of antibiotics.
- Unfortunately, she did not receive the antibiotics until four hours later. Her health deteriorated significantly in that time.
- This delay in receiving antibiotics meant the patient did not receive timely treatment for sepsis in line with the NICE sepsis guidance.
- Staff performed a CT scan (a computerised tomography scan, which creates detailed images of the inside of the body) the following morning. They prescribed another dose of antibiotics, reviewed the patient and transferred her to the intensive care unit to receive medication to support circulation.
- The patient's condition did not improve. Doctors explained to her family they could give no further treatment and started end of life care. Sadly, she died that evening.
- We found that the delays in starting antibiotic treatment and admitting the patient to the intensive care unit (to support her circulation) significantly affected her chances of survival.
- If the Trust had done what it should have done, it was more likely that the patient would not have died.

[20] HSIB (2021), 'Recognising and responding to critically unwell patients'.

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Poor handovers

Good communication between clinicians and appropriate handover between teams is an essential part of patient safety. General Medical Council guidance[21] to doctors, for example, stresses the importance of working collaboratively, communicating effectively and sharing information between teams. Equally, the Nursing and Midwifery Council Code of Practice highlights the need to maintain effective communication and keep health and care professionals informed when sharing the care of individuals, to 'preserve the safety of those receiving care'.[22] This includes the need for timely and appropriate handovers between teams. Research has identified that transfers into or out of intensive care units and when information has to be communicated to other teams during a critical care stay can be risk points for patient safety incidents.[23]

In almost half of the cases we analysed, we found failings in communication between different clinicians and teams. In one case, for example, we could not find any evidence that the Trust followed a clear and coordinated clinical management plan when a man in his seventies attended the Trust's emergency department with a twisted bowel. We found that poor communication between teams contributed significantly to the Trust failing to take urgent action to reduce the risk of bowel perforation. When investigating another case, we could not find evidence of a documented handover between teams. This meant we could not understand what actions the Trust had taken at the time to make sure the patient continued to receive adequate care.

[21] General Medical Council, 'Domain 3: Communication partnership and teamwork', Good medical practice.

[22] Nursing and Midwifery Council, The Code.

[23] Thomas, A.N., and MacDonald, J.J. (2016), 'Patient safety incidents associated with failures in communication reported from critical care units in the North West of England between 2009 and 2014'. Journal of Intensive Care Society, 17 (2), pp. 129-135.

Case study: failure to diagnose and lack of handover between teams

- A patient went to a Trust's emergency department after an out-of-hours GP told them to call 999. The patient said they had a racing heart, felt generally unwell and had pain in their forearms.
- The Trust carried out a series of checks and found them to be within normal limits. The doctor prescribed an antibiotic and discharged the patient.
- A few days later, the patient was admitted to a medical assessment unit after a GP referral for a respiratory opinion.
- A consultant reviewed them and noted they might have a blood clot and fluid around the lung.
- The consultant requested a troponin test (a blood test that can help assess heart damage), echocardiogram (a scan to look at the heart and nearby blood vessels) and repeat ECG, and prescribed a blood-thinning injection to treat the suspected clot.
- Another doctor reviewed the patient and considered a pleural effusion (when excess fluid builds up in the space between the lungs and the chest wall) rather than a blood clot. Staff gave the patient antibiotics and drained the fluid around the lung. The following day, the doctor noted the patient's symptoms were improving.
- A couple of days later, a consultant respiratory physician noted that the patient had aching pain in both arms, breathlessness and difficulty breathing when lying down. They reviewed the test results and considered the patient had congestive heart failure (when the heart cannot pump blood around the body properly), which was probably secondary to a recent heart attack.
- The consultant asked for an ECG and troponin test and prescribed medication. They left instructions for staff to triage the patient as a cardiology patient and arrange an ECG to check the heart's rhythm and electrical activity.
- The next day, the patient was moved to a ward and nurses noted that a doctor needed to do a medical review, including reviewing the ECG results.
- Sadly, the patient died the next day after suffering a cardiac arrest.
- We found multiple failings in relation to the patient's care.
- The Trust had not carried out the troponin test and echochadiogram the first time a consultant requested them, and staff did not act on early warning observations when they should have alerted a doctor.
- There was evidence of a heart attack in the ECG results, but this did not get an urgent medical review. And no medical review was carried out after the patient was transferred to the ward.

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- If the Trust had made a timely diagnosis and given appropriate treatment, there would have been an improved chance of the patient surviving. It missed an opportunity to provide potentially lifesaving treatment. It was more likely than not that the patient's death was avoidable.
- We found that communication with the patient's next of kin was flawed and incomplete, and there were failings in the Trust's complaint handling that caused them distress and frustration.

Failure to listen to the concerns of patients and their families

Listening to patients and their families is a vital part of providing good quality care and treatment that puts the patient front and centre. In our casework, we identified a small number of cases where failures to listen to the concerns of patients and their families had a clinical impact.

For example, a man who was admitted to hospital with abdominal pain raised concerns with clinical staff on multiple occasions about his care and treatment. During our investigation we found evidence that he was concerned he did not feel well enough to leave the hospital. Despite this, the Trust still considered him well enough to go home and discharged him on the same day. Two days later, he returned to hospital and died shortly after being admitted due to gastric aspiration (where vomit enters the larynx and lungs). Our investigation found that the Trust should have carried out an urgent CT scan, which would have led to the patient having lifesaving surgery.

In another example, a complainant described how he had to persuade staff to admit his mother after she had attended the Trust's emergency department multiple times. During our investigation, we found evidence that staff doubted the patient's symptoms and failed to appreciate the serious nature of her condition. Understandably, this was upsetting for the complainant who could see that his mother was very unwell. The complainant's mother died after having a stroke in hospital. This could have been avoided if she had been diagnosed correctly and treated during an earlier admission.

Summary

The themes we have identified around clinical failings are wide-ranging but will be very familiar to anyone with experience in patient safety. The caseworkers who worked on these cases observed that they reflect the types of issues we see in most of our health casework, not just those that resulted in the most serious possible outcome of a patient's avoidable death.

Although a lot can be done to reduce clinical harm and improve patient safety, and certain incidents can be prevented entirely with the right processes, systems and cultures in place, it is unrealistic to expect that all clinical errors and omissions can be eliminated. But it should always be possible to respond well, with compassion, and in a way that shows learning and accountability when avoidable harm has happened. In the next section we look at the evidence from our casework about the impact on families when this does not happen.

The ongoing impact of clinical harm: compounded harm to families

All too often in our casework, we see families who have already experienced the devastating consequences of avoidable harm suffer further distress because of the response they get from healthcare organisations. This additional harm that people experience when interactions following patient safety incidents feel closed and defensive is known as 'compounded harm'.[24] Researchers have recognised the impact of compounded harm, 'especially when people feel unheard or invalidated'.[25]

Although the idea of compounded harm is not new, it is often neglected in the process of understanding the impact of avoidable serious harm. In this section, we look at evidence of compounded harm in our casework. We highlight the experiences of families who brought cases to us, as they described it during our interviews with them.

When we looked at our casework, we identified the following scenarios that are likely to contribute to compounded harm:

- failure to be honest when things go wrong
- a lack of support to navigate systems in the aftermath of an incident
- poor-quality investigations
- failure to respond to complaints in a timely and compassionate way
- inadequate apologies
- unsatisfactory learning responses.

A failure to be open and honest when things go wrong

The duty of candour requires organisations to be open and honest with patients as soon as possible after they realise something has gone wrong. But we know from our casework that this duty is not always met. In one example, we found the Trust did not disclose the contradictory opinions it had received from different reviewers when determining whether a delay to an operation had resulted in avoidable harm. We judged that this review should have triggered action under the duty of candour, but there was no evidence the Trust had considered its responsibilities to inform the family.

In a case where a baby died after antibiotics were not given quickly enough, we found the Trust had not properly equipped its staff to acknowledge what had gone wrong. Important details about the sequence of events and the nature of the infection were not given to the parents until seven weeks after their son died. Staff even discussed deleting a recording made during a meeting when the parents temporarily stepped out of the room, because they realised what they had said might get the Trust into difficulty. This complete failure of transparency created understandable mistrust and worsened the pain and distress of the family in their grief.

[24] This term features in the Patient Safety Incident Response Framework guidance on engaging with and involving families, patients and staff following a patient safety incident.

[25] Wailling, J., Kooijman, A., Hughes, J., and O'Hara, J. (2022), 'Humanizing harm: Using a restorative approach to heal and learn from adverse events'. Health Expectations, 25 (4), pp. 1192-1199.

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Duty of candour

The underlying principle of the duty of candour is that when something goes wrong in the provision of health and care services, patients and families have a right to receive a meaningful apology and explanations for what happened as soon as possible.

The statutory duty of candour was introduced in 2014 in regulations to the Health and Social Care Act 2008.

Regulation 20 puts a legal duty on health and social care to be open and transparent with people using services and their families. It sets out actions that providers must take when a 'notifiable safety incident' happens. Notifiable safety incidents:

- are unintended or unexpected
- happen during the provision of an activity the CQC regulates
- are incidents that – in the reasonable opinion of a healthcare professional – could, or already appear to have, resulted in death or severe or moderate harm to the person receiving care.

As soon as a notifiable safety incident has been identified, organisations must act promptly and are expected to:

- tell the relevant person, face-to-face, that a notifiable safety incident has taken place
- say sorry
- provide a true account of what happened, explaining what is known at that point
- explain what further enquiries or investigations will take place
- follow up by providing this information and the apology in writing, and giving an update on any enquiries
- keep a secure written record of all meetings and communications with the relevant person.

The CQC regulates compliance with the statutory duty of candour. Organisations must have clear policies and procedures in place and make sure staff understand their responsibilities. The CQC also expects senior managers to show they have a safe culture where staff feel able to speak up and are supported to carry out the duty of candour. Failure to comply with the duty can result in enforcement activity ranging from warning or requirement notices to criminal prosecution.

Lack of support to navigate systems in the aftermath of an incident

All our interviewees spoke about the difficulties they had in knowing how to raise concerns about what happened to their family member. A lack of information was a common experience. One complainant explained: 'we didn't get any information in regards to letting them [the Trust] know about our experience, how we felt about my mum's care; all of that was sorted by me and I didn't get any family support either. I literally did it all by myself'.

Another commented:

> 'Nobody gave me any information at all. I went online and googled what to do and that was it. Nobody gave me any advice on how to complain, on what to say, or anything like that.'

We also heard some concerns about a lack of independent advice, if it came from the same organisation where the incident took place:

'I feel like it was a very distressing situation, there was no sort of advice around the complaint. I first complained to PALS which work in the hospital. I don't actually think that this is a good way for patients to complain about the hospital because the people they complain to work within the hospital.'

Where complainants were able to access independent advocacy services, this was a positive experience:

> 'I did find an organisation that supported me called POhWER, they were really helpful. I was really upset and distressed and the first lady was very patient with me, very kind, very helpful, she told me the steps to complain. Then that lady left and they gave me another advocate and she was also really helpful ... she read every single page with me, and she literally held my hand all the way through the process. So the advocates were helpful, but in regards to the hospital, there was no help from them.'

Local authorities have a statutory duty to fund independent NHS complaints advocacy. This type of advocacy is provided by trained, professional advocates who can give information, signposting and support with the complaints process. Professional advocacy can be a source of valuable information and guidance, and a way of supporting complainants through what can be a long and difficult process, although emotional or psychological support is not part of the role of professional NHS complaints advocates.

As we highlighted in 'Making Complaints Count', NHS complaints advocacy services are limited to helping people navigate the NHS complaints process. Complaints advocacy providers cannot give advice on the clinical parts of a complaint or other processes a complainant might be involved in or considering, such as coroner inquests or making a claim.[26]

[26] PHSO, Making Complaints Count, p. 32.

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The benefit of access to advocacy is something the Harmed Patients Alliance recognised in a recent report. It said: 'well-advised and supported people are more likely to take an active part in investigations without suffering compounded harm', as well as being better able to take part 'in a meaningful way in a patient safety investigation under the Patient Safety Incident Response Framework (PSIRF)'.[27]

Poor-quality investigations

Organisations should provide clear, evidence-based explanations in response to concerns, provide reasons for their decisions, and consider the impact of any failings. We routinely see Trusts fail to accept errors or the extent of what has happened and its impact. In most cases where we found a death was avoidable, the Trust had not conducted a serious incident investigation. And there were no instances of Trusts themselves reaching the same conclusion as our investigation that errors in care led to the death of the patient. Because we use evidence that organisations would have had access to, it is reasonable to expect those organisations should also have been able to identify these errors.

In one case, after delaying its response by a whole year, the Trust responded to a complainant about her mother's death by summarising what was said in a local resolution meeting (a meeting between the Trust and the complainant). We saw no evidence that the Trust conducted a full investigation into the complainant's concerns or attempted to address them in any detail. In another case, there were contradictions in the Trust's written responses and inaccuracies in its account of the care and treatment provided to the complainant's wife, who had died of a brain tumour. The Trust provided two responses a year apart. The first response accepted there was a delay in identifying that the tumour was growing, while the second response explained events differently.

Some investigations are not as thorough as they should be and crucial parts are missed out. For example, a case in which a senior house officer failed to attend when bleeped was a significant moment in understanding failures in care and treatment. But the senior house officer was not interviewed as part of the serious incident investigation that followed. Nursing staff were asked to give statements, but the senior house officer was not. This meant the Trust was unable to explain why there was a delay in responding to the bleep and missed an opportunity to understand the context of the failing. This added to the distress felt by the patient's partner, who was left with no answers to this important part of the incident.

In some instances, we found the Trust identified the clinical failings correctly but the local investigation failed to consider the impact of them. In one case, the Trust carried out an investigation and correctly identified the clinical failings that led to a mother's death from sepsis. It made an action plan for improving process, which showed it aimed to learn from the incident, but it did not consider the impact of the failings, which was that the patient's death would not have happened if they had received the right treatment at the right time. In another case, the Trust initially refused to accept that it should have identified clear abnormalities on an X-ray and did not believe this represented a missed diagnosis.

[27] Harmed Patients Alliance (2022), Signpost to Nowhere, p. 4.

Trusts can sometimes use comorbidities (when someone has more than one, often chronic or long-term, disease or condition at the same time) to minimise the impact of any failings or omissions. For example, in a case where there was a significant delay in giving antibiotics, the Trust said the patient's history of cardiac problems and low blood pressure would have limited the patient's response to sepsis. But our critical care advisor said this was not supported by the information available. Examples like these suggest an ingrained defensiveness and lack of curiosity about the causes of harm, which is sadly still prevalent in some Trusts.

Case study: failure to make the right diagnosis and poor-quality investigation

- A patient with a long-standing autoimmune disease went to a Trust's emergency department with symptoms including dizziness, poor balance and blurred vision. The Trust kept the patient overnight for further investigations.
- A doctor carried out a brief initial assessment of the patient and noted they looked unwell and pale. Later in the evening, a nurse took blood samples for testing and examined the patient using a MEWS score (Modified Early Warning Score, an early warning system based on clinical observations). This was recorded as 1.
- The Trust transferred the patient to the acute medical unit to wait for a full medical assessment.
- Later in the night, a doctor assessed the patient and noted nystagmus (involuntary flickering eye movements) in addition to earlier symptoms including blurring of vision and dizziness.
- The doctor made a working initial diagnosis of dehydration. The doctor started a care plan to continue with IV fluids, to monitor IV fluids in and urine out, and to refer the patient to the ophthalmic team if the visual changes did not improve with rehydration.
- Afterwards, the nursing team noted further heart rate increase and that the patient had not passed urine since they went to the acute medical unit. The Trust recorded a MEWS score of 4 – 1 for the increased heart rate and 3 for the lack of urine output.
- The patient told the doctor who attended for review that they were unable to pass urine. The patient was catheterised for urine drainage, which eased their discomfort.
- The following morning, a family member reported a rapid change in the patient's condition. They were concerned about the patient becoming drowsy and unable to speak. This prompted the immediate escalation of their treatment.
- Tests and scans were ordered to try to identify the underlying cause of the change. Shortly after, the patient's condition suddenly got worse and they eventually lost consciousness.

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- The CT head scan results showed signs of hydrocephalus (fluid pressure in the brain caused by a blockage stopping fluid from draining out of the skull) and a bleed on the brain. The patient was immediately transferred to the nearest Regional Neurosurgical Department for surgery to relieve the pressure and stop the bleed.
- Despite having two operations to try saving their life, sadly the patient never regained consciousness and died a few days later.
- The surgeon's notes show they found a growth in the brain during surgery, which caused the hydrocephalus and eventually had also been the source of a bleed on the brain.
- We found several failings in the care the Trust gave the patient.
- We found a failing to complete a full neurological assessment and order a CT head scan in response to signs of nystagmus noted by the doctor at the acute medical unit. Although the nystagmus was identified correctly, the doctor missed the significance.
- This led to a missed opportunity to diagnose and treat the patient's condition and potentially avoid their death.
- We found there was failure to make sure the MEWS score was monitored hourly following the MEWS score of 4 being recorded.
- We also found that the Trust's complaint investigation failed to identify and address these issues, which added to the distress and grief suffered by the patient's family.

The Patient Safety Incident Response Framework (PSIRF)

The PSIRF is being rolled out across the NHS, with a deadline for implementation of autumn 2023. While this is too recent to be relevant to the cases in this report, it represents the future for the approach to patient safety in the NHS.

What the PSIRF is changing

The PSIRF replaces the Serious Incident Framework. Unlike the Serious Incident Framework, it is not an investigation framework that prescribes what to investigate (although there are still circumstances where a patient safety investigation will be mandatory: incidents meeting the 'learning from deaths' criteria; Never Events[28] – safety events that are 'wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'; deaths of patients detailed under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies).

Instead, the PSIRF promotes a range of system-based approaches for learning from patient safety incidents. This includes alternatives to an investigation such as a multidisciplinary team review and a 'swarm huddle' – when staff gather to quickly analyse what happened immediately after an incident and decide how to reduce future risks.

The PSIRF is intended to be more flexible, allowing organisations to tailor their response to patient safety so that it is relevant for their contexts and the populations they serve. This flexibility will allow organisations to focus resources on where they can really make an impact, rather than having to always conduct an investigation where that might not lead to new learning or create change. The framework represents a move away from root cause analysis and towards approaches that look at the wider system and human factors.

Under the framework, NHS organisations need to develop a plan and a policy outlining how they will respond to patient safety incidents. There is a focus on compassionate engagement with patients and families, with specific guidance on how to do this well.

In terms of oversight, the framework requires a PSIRF executive lead on each NHS Board, as well as an integrated care board lead who will work with providers on their responses to patient safety. The suggestion is that oversight focuses more on collaborative working and collecting qualitative data, rather than requiring lots of quantitative measures. As stated in the guidance, it 'focuses on engagement and empowerment rather than the more traditional command and control'.[29]

Who the PSIRF applies to

The PSIRF is a contractual requirement under the NHS Standard Contract so it will be mandatory for acute, ambulance, mental health and community healthcare providers. This includes maternity and all specialised services. Primary care providers (for example, GPs) may adopt the PSIRF but are not required to at this stage.

[28] NHS (2018), 'Never Events policy and framework'.
[29] NHS England, Patient Safety Incident Response Framework supporting guidance: Oversight roles and responsibilities specification, August 2022.

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Failure to respond to complaints in a timely and compassionate way

As we are the final stage for unresolved complaints in the NHS, we usually expect people to complain to the organisation they are unhappy with first. This gives the organisation the chance to look into the concerns and, where needed, put things right. We frequently see examples of unacceptable and unreasonable delays in responding to complaints, and failures to keep families informed and updated about the progress of their case. These delays and failings in communication often cause more distress and frustration for complainants and their families at a difficult time.

Case study: failings in care and poor complaint handling

- A patient with bipolar disorder (a mental health condition that affects your moods) attended a hospital's emergency department by ambulance, due to shortness of breath they had been experiencing for a few days.
- Staff arranged a chest X-ray and diagnosed inflammation of the lungs. This inflammation caused impaired oxygen absorption which resulted in respiratory failure. This resulted in low oxygen levels causing the patient to be confused and agitated.
- The patient was admitted to the intensive care unit and prescribed antibiotics and continuous positive airway pressure (CPAP, a type of breathing support).
- A few days later, the patient could breathe without respiratory support and maintain oxygen levels. The consultants considered the patient to be medically stable and transferred them to a ward.
- A couple of days later, the patient had a cardiac arrest. The doctors resuscitated the patient and transferred them back to the intensive care unit.
- Staff carried out an electrical brain wave test, which showed irreversible brain damage. A neurology assessment also confirmed that recovery was unlikely.
- The consultant decided to withdraw critical care support. The patient died later that week. The cause of death was recorded as severe hypoxic brain injury (when the brain does not get enough oxygen) and cardio-respiratory arrest (loss of breathing and heart function).
- We found that staff failed to observe the patient as frequently as they should have. If this had happened, they may have recognised the patient's health deteriorating earlier and called for senior medical input before the cardiac arrest happened.
- We also found the Trust failed to provide planned, focused, one-to-one care for the patient during their time on the ward. If the Trust had provided one-to-one care, staff would have identified the patient's cardiac arrest much sooner.

- If this had happened, it is likely the patient would have been resuscitated without suffering the irreversible brain damage that led to their death. It is likely the patient's death could have been avoided.
- We also found failings in the way the Trust handled the complaint.
- When the patient's daughter complained, the Trust took over six months to arrange an initial meeting to discuss it and failed to provide a written response.
- Before we began our investigation, we asked the Trust to provide a written response. It agreed to do this by the end of the following month but did not provide it until a year later. This meant the complainant only received a response to her complaint about her mother's death two years after complaining to the Trust.

In one case, a man who complained about the death of his wife from a brain tumour had to wait two years for the Trust to conclude its investigation.

In interviews we conducted, complainants described the process of trying to resolve their complaint with Trusts as 'long and torturous', 'a long, dragging sequence of events' and 'very lengthy and distressing'.

Often, Trusts will explain that the complaint department was understaffed or dealing with high staff turnover. We know from previous research that complaint handlers in the NHS may not be sufficiently empowered or trained to resolve a complaint.[30]

Treating complainants with dignity and compassion is an essential part of resolving a complaint, but we found instances where organisations failed to do this. For example, in one of the complainant interviews, a mother whose son died of a pulmonary embolism told us:

> 'At some point a doctor from the Trust phoned my [other] son to tell him that his brother would have died anyway and there was really no point in carrying on with this.'

The same complainant told us she felt the Trust 'just weren't interested. It was over, it was done with, and they didn't want to know'.

In another interview, the complainant told us their first meeting with the Trust took place in the same ward where her mother had recently died.

[30] PHSO (2020), 'Making Complaints Count: Supporting complaints handling in the NHS and UK Government Departments'.

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The complainant said this was so insensitive to her and her family that 'it felt cruel'. The same complainant told us she did not feel like the Trust was interested in what she had to say:

> 'I didn't think they were interested. I felt like my mum had passed away and so it wasn't a concern for them. It was almost like, you know, she's gone now and that was it.'

NHS Complaint Standards

We are committed to supporting and improving frontline complaint handling. We developed the NHS Complaint Standards to support organisations to provide a quicker, simpler and more streamlined complaint handling service. The Standards apply to NHS organisations in England and independent healthcare providers that deliver NHS-funded care.

The Standards have a strong focus on:

- early resolution by empowered and well-trained people
- all staff, particularly senior staff, regularly reviewing what learning can be taken from complaints
- how all staff, particularly senior staff, should use this learning to improve services.

The Complaint Standards are based on 'My Expectations', which sets out what patients want to happen when they make a complaint about health or social care services.[31] The Standards and the guidance modules describe how staff can meet those expectations.

We worked with 11 pilot sites and over 70 'early adopters' across the NHS in 2021-22 to help test how the Standards, supporting materials and training can support frontline complaint handling.

Feedback from the pilot has been overwhelmingly positive, with NHS staff telling us the support on offer will make a real, practical difference and promote consistency. Throughout 2023, we will be working to embed the Standards across the NHS.

Inadequate apologies

Guidance from NHS Resolution makes it clear that apologising is not an admission of fault or liability.[32] The same guidance highlights that organisations must make meaningful apologies when things go wrong. It states that a meaningful apology 'is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them'.

[31] PHSO (2014), 'My expectations for raising concerns and complaints'.

[32] NHS Resolution, 'Saying sorry': 'The Compensation Act 2006 states; "An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty"'.

But we still see organisations that fail to give a genuine apology. Organisations may say sorry and accept that failings happened, but it is rarer that they offer a clear and unreserved apology that shows they have understood the impact of those failings on the patient. In 'Making Complaints Count', we identified how a culture of defensiveness can result in staff feeling like they are not allowed to say sorry. Advocates also told us they often see organisations send apology letters that say 'I'm sorry if you felt that...' rather than offering a sincere apology.[33]

In one case, the apology letter repeated that the Trust had been asked to accept the failings we found, but it did not go on to do this. Instead, it referred to what the Ombudsman 'felt', which suggests a lack of acceptance of our findings and the learning they offer. The apology letter did not accept responsibility for what happened or even refer to the patient or the fact that they died. In another case, we considered that the Trust's apology letter did not accept that its failings led to avoidable serious harm. In its first apology letter to the complainant, the Trust only apologised for the complainant having 'had cause to raise concerns'. It was clear the Trust did not accept responsibility and had not apologised for the impact of the failings. It was only after repeated contact with the Trust on the content of the apology letter that it gave the complainant an unreserved apology for the avoidable serious harm it caused to the patient.

One complainant told us that after our investigation they felt the 'Trust finally had to accept that they had got it wrong'. But they also said:

> 'I don't think that they did it with a good grace. I think it was just a formula ... They weren't sorry that they'd done it, they were sorry they'd been caught.'

Unsatisfactory learning responses

Most complainants want assurances that something is being done to prevent the same mistakes from happening again. In our recent research on motivations for complaining, 93% of respondents said 'ensuring that others don't face the same issues in the future' was either very important or important in their decision to complain.[34] Similarly, in our interviews with complainants, they all said part of the reason why they complained was to make sure the same thing does not happen to other patients, families and carers.

Being able to show that learning has happened is vital if families are to feel their complaint has achieved its purpose. Responses that do not feel meaningful can leave families feeling badly let down and frustrated.

While we do see good examples of thorough action plans, we frequently see less robust responses. These are a missed opportunity for learning from avoidable serious harm and taking action to prevent it from happening again. In one case, we had to follow up multiple times to make sure we were satisfied with the proposed action plan. The Trust did not plan to audit its proposed new processes, so there would be no way of knowing if they were effective.

[33] PHSO (2020), Making Complaints Count, p. 14.

[34] PHSO (2023), Outreach Research.

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In one interview, the complainant told us:

> 'I knew that all the things they said they were going to implement to change things, wouldn't change the way the ward was operated and the way nurses behaved, or the way that the actual patients on the ward felt. It was all just more rules, and probably just more bits of paper for the nurses to fill in, but not translating to an effect on the ward.'

Another complainant told us:

> 'I don't believe they've learned one lesson.'

It is clear that, far from being a process that promotes learning and provides resolution and healing, the response to families following an incident frequently creates further harm and distress. This is completely unacceptable. Reducing compounded harm must be an urgent priority for everyone working to improve patient safety.

Our recommendations

The issues we have identified are complex. They reflect the fact that healthcare is a web of interactions, behaviours and processes, underpinned by deeply ingrained cultures. If there were readily available, easy solutions to tackle clinical failures and end compounded harm, they would have been implemented long ago.

Facing up to this complexity, we have focused on two themes in our recommendations.

1. Accountability for a robust and compassionate response to harm, which supports learning for systems and healing for families

Our casework shows that many local investigations are not good enough. It cannot be right that in so many instances, the Ombudsman finds errors that the Trust has not identified at an earlier stage. The gap between the findings of local investigations and the findings of our investigations suggests how defensive some NHS cultures can be. In some Trusts, there is still an embedded lack of curiosity about what has happened and what can be learned.

It is important to recognise that our evidence base is just one snapshot in a much bigger picture. We understand that few people will have the energy to keep going and bring their case to the Ombudsman, having been through the trauma of grief, an investigation and a complaints process. This means what we see through our casework is likely to be the tip of the iceberg.

We must improve investigation quality and practices so they aid learning and promote healing, rather than adding to compounded harm. The HSIB has done important work to upskill NHS staff in best practice investigation methodologies, and the PSIRF is an excellent framework to take this even further. There is a lot to welcome in the framework's systems-based approach and emphasis on compassionate engagement.

While we want to endorse the approach the PSIRF outlines, we need to be realistic about how far there is still to go. There is a gap between the welcome rhetoric in PSIRF guidance documents and the defensive behaviours from some NHS leaders we still see in our casework, as evidenced in this report.

The additional flexibility the PSIRF offers (giving Trusts more autonomy to decide when a safety investigation is needed) might present a risk that Trusts with poor cultures do not carry out safety incident investigations when they should. This possibility is not acknowledged in the PSIRF oversight guidance. Rather, the emphasis on 'proportionate responses' focuses more on making sure unnecessary investigations are not conducted if they would repeat old ground or would not lead to learning.

The PSIRF needs to be accompanied by sufficient monitoring and support for families.

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We recommend that:

- **Integrated care boards, with oversight from NHS England, should closely monitor the impact of the PSIRF to identify any negative consequences of the new flexibility it offers, which gives Trusts more autonomy to decide when a patient safety investigation is needed. This should include paying special attention to the balance of patient safety investigations versus other learning responses in Trusts (or service areas of a Trust) where there are poor CQC ratings for safety and leadership, or where other national bodies have raised concerns (recommendation 1).**
- **As part of their quality monitoring role, the PSIRF executive lead on each Board should look at any discrepancies between local and PHSO investigations, or other independent investigations, and make sure the Board discusses them. This should include where local investigations did not take place, or did not find that things went wrong, but PHSO or another independent oversight body later identified failings (recommendation 2).**

The PSIRF recognises that genuine apologies are critical to avoid compounded harm. As we found in cases we analysed, apologies are often still not good enough and duty of candour is not always implemented as it should be. It is unacceptable that Trusts still fail in this duty nearly a decade after it was introduced. Again, this is symptomatic of a defensive culture in some Trusts. Duty of candour is the right policy, but it needs more attention and monitoring.

We recommend that:

- **The Department of Health and Social Care and NHS England should further scrutinise the lack of compliance with duty of candour. They should review the operation of duty of candour to assess its effectiveness and make recommendations for improvement (recommendation 3).**

We welcome the model of family engagement outlined in the PSIRF. But we know that, for the foreseeable future, it will continue to be very challenging for families affected by safety incidents to navigate the complex NHS landscape when they raise concerns and seek answers. They are often very aware of the power imbalances in dealing with professionals who are familiar with the processes and systems that they are coming to for the first time. In this context, advocacy is an essential service, not a 'nice to have'.

While there is a statutory duty for local authorities to commission NHS complaints advocacy, these services are often limited to helping people navigate the NHS complaints process. As we noted in 'Making Complaints Count', there are concerning gaps in access to more specialist services that may be important for families affected by patient safety incidents.

We recommend that:

- **The Department of Health and Social Care should commit to funding further independent advocacy to support harmed patients, families and carers when they raise concerns or seek answers after an incident (recommendation 4).**

2. Evidencing that patient safety is a top Government and NHS priority

The right patient safety framework is not enough on its own to drive change. NHS leaders and frontline staff need to be in no doubt of the priority placed on patient safety.

In some ways it is strange that this should need emphasis: patient safety is about the NHS' core purpose to do no harm. But there are clear signs that patient safety is not prioritised at the moment, however much rhetoric there is to suggest otherwise.

First, we are becoming too used to seeing repeated failings. This is especially stark in maternity services. In his inquiry in East Kent, Bill Kirkup acknowledged the disappointing familiarity of the findings to those he made in Morecambe Bay seven years earlier. The fact that inquiries many years apart find the same failings is met with dismay, but not always outrage or even surprise. There is almost an acceptance that this is 'how things are'. This inertia undermines the difficult work underway to change cultures and manage patient safety more effectively.

Second, political leaders have created a confusing landscape of organisations, often in knee-jerk rection to patient safety crisis points. HSIB, the Patient Safety Commissioner, PHSO, NHS England, NHS Resolution and more than a dozen different health and care regulators all play important roles in patient safety. But there are significant overlaps in functions, which create uncertainty about who is responsible for what. This means patient safety voice and leadership are fractured. This is not due to a lack of dedication and professionalism from those tasked with championing patient safety. The problem is structural.

The Government must consider the case for streamlining some of these functions, for the benefit of people who use the NHS, their families and carers. This is not about reducing investment in patient safety. It is about creating a system that is coherent and easier to navigate, based on evidence and engagement with patients, families, NHS staff and leaders. We recommend that:

- **The Department of Health and Social Care should commission an independent review of what an effective set of patient safety oversight bodies would look like. The review must include meaningful engagement with NHS leaders, staff, patients and families (recommendation 5).**

Patient safety must be a consistent priority over the long term. It must not be subject to changes of emphasis or importance each time there is a new minister or leadership change in the NHS. We recommend that:

- **The Government should seek cross-party support for embedding patient safety and the culture and leadership needed to support it as a long-term priority (recommendation 6).**

Third, it is not possible to claim to prioritise patient safety while avoiding difficult political decisions about the workforce the NHS needs. Patient safety will always be at risk in environments that are understaffed and where staff are exhausted and under unsustainable pressure. No matter how effective the safety systems and process, it is not possible to run a safe service without the right numbers of staff. Many patient safety commentators draw parallels between the NHS and aviation. In aviation, a plane would not take off without the right number of staff, with the rights skills, who have had enough rest, support and training to be able to operate safely.

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Tackling workforce shortages goes beyond political decisions about resourcing. It is about making the NHS a place where people want to work and stay because it is somewhere they feel valued, not just because it is a vocation. We must break down the false dichotomy between the interests of patients and staff, recognising that a system that does not treat its workforce with humanity and compassion will struggle to extend these qualities to patients and families.

We recognise the Government has promised to publish a new NHS workforce strategy. At the time of writing, this is expected 'shortly'. But for this to properly address the underlying causes of NHS staffing pressures, it needs cross-party consensus. In a sector where it can take nearly two decades to train a consultant doctor, a workforce strategy will only succeed if there is support from across the political spectrum, and far beyond one parliamentary term.

We recommend that:

- **The Government should urgently produce its long-awaited long-term workforce strategy, with cross-party support, to increase the numbers entering and staying in the workforce across clinical and non-clinical roles. This strategy must:**
    - **include independent, evidence-based and fully costed projections of future workforce requirements**
    - **include detailed plans for training and recruiting new staff, retaining staff already working in the NHS and attracting those who have left to return**
    - **take account of the mix of different professional skills required, rather than just total numbers in the workforce, and how existing professional skills can be deployed where they are most needed (recommendation 7).**

The Department of Health and Social Care should write to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication of this report to provide an update on progress against recommendations 3, 4, 5, 6 and 7.

NHS England should write to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication of this report to provide an update on progress against recommendations 1 and 3.

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E02931971
ISBN: 978-1-5286-4244-6

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This attachment can be found at: WIT-46754 to WIT-46773	meeting now which focusses on all aspects of Integrated Governance. ATTACHMENT – 1-1 DIVISIONAL MEDICAL DIRECTOR TEMPLATE document located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*	Covid19 pandemic. The process this replaced with 1-1 meetings with AMDs did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Divisional Medical Director Meetings **These attachments can be found at: WIT-46730 to WIT-46731; WIT-46732; WIT-46733 to WIT-46734; WIT-46735; and WIT-46736 to WIT-46753**	As the Divisional Medical Director roles have been established over the past few months this group pf senior doctors now meets fortnightly rather than monthly amongst other agenda items to describe governance assurances in their respective areas. ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR AGENDA document can be located at – *S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1* ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MINUTES document located at *S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35 . DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*	I instigated this through the development of the DivMD roles in Spring of 2022. The process this replaced with 1-1 meetings with AMDs did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Weekly Governance Debriefs **This attachment can be found at: WIT-48231 to WIT-48238**	These meet weekly and include professional directors, DivMD, governance leads in all areas, leads for Improvement and education. ATTACHMENT – WEEKLY GOVERNANCE DEBRIEF TEMPLATE document located at *S21 No 29 of 2022, 113. Weekly Governance Report Template*	I instigated this approximately 18 months ago to draw the elements of governance across the Trust in answer to the Question “Are we safe this week, will we be safe tomorrow?” The process did not exist previously and, as

An addendum amending this statement was received by the Inquiry on 15/01/24 and can be found at WIT-105947. An amended addendum was received on 16/01/2024 and can be found at WIT-106615 to WIT-106616. Annotated by the Urology Services Inquiry.

SCHEDULE

[No 105 of 2022]

Qualifications

1. Please set out all professional roles held by you and your qualifications.

Professional Roles		
Role	***Employer(s)***	***Dates***
Registered Nurse	*Various – See below*	*1974-1978*
Registered Midwife	*Royal Victoria Maternity Hospital*	*1979 -1980*
Ward Manager	*Royal Victoria Hospital (RVH)*	*1980- 1983*
Ward Manager	*Armagh City Hospital*	*1983-1985*
Registered Home Manager	*Manor Court Private Nursing Home, Dungannon*	*1985-1987*
Director of Nursing & then Chief Executive	*Sandown Private Nursing Home Group*	*1987 - 1997*
Managing Director	*Tamaris Healthcare (NI)*	*1997- 2002*
Managing Director	*Beneveagh Healthcare*	*2002 – 2005*
Non-Executive Director (NED)	*Armagh and Dungannon Health and Social Care Trust*	*1998-2002*
NED	*Southern Health and Social Care Board*	*2003-2007*
NED	*SHSCT*	*2007-2011*
Board Chair	*SHSCT*	*2011 -2020*
Board Member	*Southern Education and Library Board (SELB)*	*2001-2011*
Lay Panel Member *Courts & Tribunal Services*	*Care Tribunal*	*1998 -to date*

15th February 2016- 30th November 2020	Southern Health and Social Care Trust	Non-Executive Director
01st November 2014 – 31st October 2021	National Lottery Community Fund	Committee Member (Northern Ireland)
01st December 2020 – current	Southern Health and Social Care Trust	Non-Executive Chair

4.3 Employed roles

Dates	**Organisation**	**Role**
March 2000 – March 2003	Citywide Training Consortium	Project Manager
March 2003 – October 2005	Training for Women Network	Business Operations Manager
March 2007 – July 2007	Belfast Metropolitan College	Merger, Project Manager
November 2005 – March 2010	Belfast Metropolitan College	Associate Lecturer
April 2010 – 31st August 2020	Eileen Mullan	Self-Employed Trainer & Facilitator
01st September 2020 - current	Strictly Boardroom Ltd	Director

4.4 Qualifications

Year	**Qualification**
1996	BA Hons Degree in Business Studies
1998	Post Graduate Certificate in Management
2001	Diploma in Management Practice

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

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

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	January 2022.

Trust Endowments and Gifts Committee

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

Performance Committee

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

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

		also provides a 'deep dive' into a service area at each meeting providing further assurance to the committee and then onto the Trust Board.

I have also attached Appendix 4, Board Assurance Framework, which outlines the details of how I gain assurance that the systems are working.

Q5	**It would also assist the Inquiry if you would summarise the key roles and responsibilities which exist within this management structure, to include committees and sub-committees of the Board, and set out the tenure of the people in those posts as at the date hereof. Have you had any issues with staff retention in those posts or with continuity of staff which has caused you concern? If so, please explain your concerns in full.**
Response	The response to Question 4 provides the details of committees and sub-committees. I have detailed below the name and titles of all attendees at all committees and their tenure. With regards to your specific question about staff retention and whether this has caused me a concern I would not have any concern about this issue during my tenure. It was clear when I came into post I needed to build a new team and therefore I appointed a new Medical Director, Director of Mental Health and Disability, Finance Director and Director of Nursing, Midwifery and AHP. Therefore my challenge moving forward was not one of retention, but rather of building a new team, However I do acknowledge that the Trust had a period of significant Chief Executive instability before I joined in March 2018 and there is no doubt in my mind I had a lot to do to steady the ship. My main focus was twofold. Firstly to recruit a substantive Senior Management Team and secondly to create a strong governance environment. (I have described both of these elsewhere in the document). Accepting the position I inherited I would consider that during this process of creating steadiness it is likely that identification and addressing of problems was not optimal ***Senior Management Team***

Name	Roles and Responsibilities	Tenure
Shane Devlin	Chief Executive	*March 2018 - present*
Dr Maria O'Kane	Medical Director	*December 2018 - present*
	Director MHLD	
Melanie McClements	Director Acute Services	*June 2019 – present*
Colm McCafferty	Interim Director CYPS	*September 2021 - present*
	Exec Director Social Work	
Heather Trouton	Exec Director of Nursing	*January 2018 - present*
Catherine Teggart	Director Finance, Procurement and Estates	*September 2021 - present*
Aldrina Magwood	Director Performance and Reform	*February 2017 – present*

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GMC, and so there's that lively tension. So there were some lively debates at times, surely, yes. As the years, I think -- and I have to mention the austerity issue, it became more and more a preoccupation. The phrase that sticks in my mind most is "3% efficiency savings year on year". That obviously was mandated of the senior management team. I didn't agree with it.

22 Q. I'm going to take you to that just in a moment and see how that debate worked out. But in terms of the support that you felt from above and in terms of the support that you had to do the job, you mention that you were supported by one Band 8 manager, Mrs. Brennan. How well supported did you feel in the role?

A. It started off very well. Anne Brennan had worked there for all of those years with Paddy Loughran, so that was really important. Another person, Stephen Wallace, likewise. So that continuity was very useful. It was a very small department and it was very tight, but we were a good team and well organised.

What I didn't realise and what I look back on now and see is that from the professional point of view, I'm the only doctor at the senior management team and I'm the only doctor on the Trust Board. There were times I would have thought not so much supported, I would have liked actually more challenge, questions. Sometimes I would give an opinion to Trust Board and I would be hoping that someone would push me and ask me questions and get me to think, you know.

reasonably mitigate the problem with cover from the general surgical registrars.

n) I responded to a review led by the Director of HR, Kieran Donaghy of Directorate responsibilities at senior management level by suggesting that the Director of Nursing should take responsibility for Infection Prevention and Control from me, in order to free up more of my time for clinical governance generally. However, this was not agreed by the chief executive, Mairead McAlinden (see email of 11th Aug 2014, doc ref 20140811) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20140811_RE CX RESPONSE TO DR SIMPSON IPC management review.pdf).

o) To illustrate the prevailing culture of the time across the NHS and the emphasis in the SHSCT placed on financial breakeven and year on year efficiency savings, I would draw attention to the following.

The Trust was asked to provide the HSC Board and Department of Health with a contingency plan to produce efficiency savings in July/August 2014. My response to the chief executive (see emails on 13th and 14th August 2014, doc ref 20211208, doc ref 20140813) (these can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211208_FW Medical Directorate Contingency Plans 1.pdf and Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20140813_Medical Directorate Contingency Plans.pdf) was that my medical Directorate was unable to contribute to this because the activity of the Directorate was focused entirely on professional governance and patient safety. Indeed, the instruction to Trusts from the Chief Executive of the HSC Board (see doc ref 20140815 Confidential TB minutes, page 2 paragraph iii) (this can be located at can be located at Attachment folder S21 26 of 2022- Attachment 1) was that none of the contingency plans should negatively impact patient safety. Despite this, the chief executive, as Director for clinical governance, decided that all clinical governance activity could be stepped down and so return those in post to front line clinical duties. In this was to be included the Band 3 post for patient safety audit from my Directorate. I did not agree with this and expressed my reservations about these proposals to Trust Board at a special meeting in August 2014 (see doc ref 20140815 Confidential TB minutes, last paragraph page 4) (this can be located at can be located at Attachment folder S21 26 of 2022- Attachment 1) . However, the minutes go on to state that 'members approved the draft contingency plan for submission' (penultimate paragraph page 5). On reflection, I do not believe this was an accurate record of my position. During the meeting, I remember clearly asking for my reservations to be contained in any correspondence to the HSC Board and Department. These were, essentially, that clinical governance would be even more important if service provision was to be reduced or paused in order to achieve financial

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

breakeven. Thankfully, implementation of the contingency plan as detailed above was not required. Unfortunately, however, the staff referred to in the proposed contingency plan had already been made aware of its content and the potential disruption of their work.

p) Regarding improvement projects in Urology, I wrote to Sam Hall, CD and Robin Brown, CD about a proposal from Peter Beckett, AMD for Primary Care in 24th Sept 2014 (doc ref 20211206 and 20140924) (these can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211206_FW urology.pdf and Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20140924_RE urology.pdf) to improve referral pathways from Primary Care to Urology. Mr Hall commented that the Urology consultant Mark Haines would lead on this and that Aidan O'Brien was supportive.

q) The email of 6th Oct 2014 (doc ref 20141006) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20141006_Deanery Visit - Urology Postgraduate_ActionPlans_updated_06october2014 and 20141006_Deanery Visit - Urology Postgraduate_ActionPlans_updated_06october2014_ATTACHMENT) details the action plan in response to a NIMDTA Deanery visit to assess post-graduate training in Urology. The action plan was subsequently approved by NIMDTA. The original grading of B1, Satisfactory was then uplifted to A2, Good (see Medical Director report to Trust Board doc ref 20150129) (this can be located at Attachment folder S21 26 of 2022-Attachment 2). In effect, Urology in the SHSCT retained its status as being suitable for the placement of trainee doctors as had been the case prior to my appointment in August 2011.

r) The email correspondence of the 17th Oct 2014 (doc ref 20141017) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20141017_FW Litigation Department requests Mr Aidan O'Brien URGENT.pdf) and 20th Oct 2014 (doc ref 20141020 and 20211206) (these can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20141020_RE Litigation Department requests Mr Aidan O'Brien URGENT.pdf and Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211206_FW Meeting re a consultant urologist.pdf) refers to correspondence from me and my litigation department to Mr Eamon Mackle, AMD and Aidan O'Brien regarding his tardiness in responding to requests for information and 'involvement' reports. Mr O'Brien provided a detailed apology (see email correspondence above) and to the best of my knowledge did respond appropriately to said requests for information.

Received from John Simpson on 01/07/2022. Annotated by the Urology Services Inquiry.

appears from what you're saying that those budgetary considerations, and the emphasis which your predecessors maybe put on delivery as opposed to quality and safety in terms of audit and all that goes with that, those were choices that are made because of the context, the budgetary context in which the Trust has to inhabit? 14:28

A. Yes, and I think, you know, there's an old adage which is "What gets measured gets done". Right. So at a point in time in the past what got measured was how much money you spent and how much activity you did. Right. There was less attention given to - and it's difficult to put a figure to it - quality and safety. So the two things that were easily measurable were done extremely well in relation to that. But then behind that, I believe that that was at a cost in terms of the clinical governance construction within the Trust. 14:28 14:29

145 Q. So when we go back to my question about how the senior leadership team - and maybe my premise is wrong? I said Senior Leadership Team standing in Craigavon Hospital June 2020, before Mr. Haynes and Mrs. Corrigan do their scoping work, you think all is well, obviously the June Champion Report freshly delivered late the previous year, and you have to work through some structural changes which are obviously very important, but it doesn't seem to me that you or your colleagues in the Senior Leadership Team had a sense of - and take the cancer services as our primary example, you didn't have a sense of how degraded the governance 14:29 14:29

	One weakness, from a personal reflection, is that during my early tenure the relationships between me and the Chair, Roberta Brownlee (whose tenure ended in November 2020, were not as strong as they could have been. Outside of public Trust Board meetings we had clashed a small number of times on the difference between the roles of a Chief Executive and a Chair. In my opinion, given the lack of consistency of personnel in the Chief Executive post prior to my tenure, the Chair had understandably become more involved in the operational delivery of the Trust. As the new Chief Executive, I found her approach 'overreaching' and in many cases unhelpful. On reflection, I know that this imperfect relationship may have had an impact on the functioning of the Board and I know, through discussion, some members of SMT found the relationship with the Chair difficult at times. I have provided further understanding of this issue in question 69 In some cases I felt undermined by the Chair as she often chose to interact directly with the members of SMT outside of my knowledge.

Q69	**Was the Board, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?**
Response	In this answer I can describe my experience from my tenure. As to the period before my tenure, previous Chief Executives and Directors would be better placed to respond. As you can see from the examples given in response to question 23, there is no doubt in my mind that, during my tenure, the Trust Board invariably were open, transparent and challenging with regards to identifying concerns and implementing lessons learned. Specifically with regards to Urology, during my tenure when items were brought to Trust Board I did not feel that the conversation was quite as open as with other topics. On reflection, I would question the total commitment of the Chair of the Trust to be totally open with regards to her willingness to criticise Urology and, specifically, Mr O'Brien. At the confidential meeting of the Trust Board on the 22 October 2020, we tabled the details of the case so far and strongly debated the concerns with regards to Mr O'Brien. I have included a section of the minutes below *"The Chair advised that Consultant A had written to herself in June 2020, the content of which she had shared with the Non Executive Directors in which Consultant A raised concerns at how the HR processes were being managed and requesting that his formal grievance and its included Appeal are addressed. The Chair was advised that this matter was being progressed through HR processes. The Chair also raised the fact that a number of different Urology Consultants had been in place over the years and asked why they had not raised concerns about Consultant A's practice and similarly, why had his PA not raised concerns regarding some delays in dictation of patient discharges. The Chair also asked should a GP not have recognised the prescribing of Bicalutamide as an issue?"* I was left with the strong impression during the meeting that the Chair was advocating on behalf of Mr O'Brien, a feeling which was shared and relayed to me by a number of SMT colleagues. It was common knowledge amongst the Trust Board and the SMT that the Chair had previously been a patient of Mr O'Brien and that she was a personal friend. I felt aggrieved that the Chair had not declared a conflict of interest in the conversation at the Board meeting. I discussed my concerns with members of SMT and was considering what I should do. A few days later (I cannot recall the exact date as I did not note the time and date of the

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Can you help us just with some examples of what you say were clashes on the difference between your role and hers?

A. Yes. The role of the Chair, for me, is obviously to have overall responsibility for the running of the Board and to be assured of the governance of the organisation. The job of the Chief Executive is to ensure the organisation delivers to its objectives within that framework.

It would not have been unusual for the Chair to have made direct approach to Directors to enquire about issues, to ask them to do certain things. An example of that, for example, we discussed yesterday Mrs. Gishkori and Mrs. Gishkori's exit from the organisation. In the background, unbeknown to me, the Chair was having conversations with Esther to try and encourage Esther to take the job that I was suggesting that we wanted to explore. It was this idea that the Chair had huge authority, huge power, had been in the organisation and its predecessor for potentially 16 years, I think probably, she was a Non-Executive Director in the predecessor and then became of the Chair of the organisation. In many cases I found that if I were to want a non-executive to work with me on anything, I had to formally request permission to do so. However, the Chair was more than willing and able to walk down the corridor and start to have conversations with executive directors about things

A. I think in terms of clashing as opposed to -- we certainly clashed on, or we clashed on the issue of the governance, but we also clashed on the issue when there was an event that we were running, and very openly the Chair was unhappy with what I had done with regards to -- I would be regularly meeting the Permanent Secretary every week I would meet the Permanent Secretary. The Permanent Secretary was then coming down to visit theatres in Dungannon, and I went to visit the theatre in Dungannon with the Permanent Secretary and I asked the Permanent Secretary to come back to the organisation. She was, I think she described it as horrified that I would have invited the Permanent Secretary into an organisation without her knowledge and those kind of things. We just clashed on certain issues.

146 Q. Yes. You go on to say in this part that this approach, on reflection, or this imperfect relationship on reflection may have impacted on the functioning of the Board. What do you mean by that?

A. I think what I mean by that, and having worked for other Chairs, I felt less comfortable and less confident to simply walk through the Chair's door and say, Chair, what about this, what about this? I also found that if I were to give any feedback that was viewed as negative in any way, that was not received as an opportunity for learning. Having now, as I say, worked with a lot of Chairs and having been on a board since 2009, I do not feel I had the relationship with

Trust. At each review the reporting systems and structures were always reviewed to be assured that the lines of responsibility knew exactly what was ongoing and the system alerted failures quickly.

Governance Leads were in each Directorate reporting to their Director, and regular Governance meetings took place with each Director of their specific area outside of the Board. These Directorate Governance meetings then fed into the wider Board agenda through the Governance Committee. From recollection the Chief Executive had overall responsibility for Clinical Governance but that changed in 2018/19 to the responsibility of the Medical Director. The Medical Director had a team of staff to assist with this particularly critical area. It was the CX who always informed me of any Governance issues (no SMT member that I can recall ever informed me).

Any CX who wanted to review Governance processes would have prepared a paper with Terms of Reference for the Board for information to keep the Board informed and to involve Board members in the review process. We had several NEDs who had excellent experience in Governance issues generally.

As mentioned previously I do not recall Urology specifically coming to the Board during 2017 and thereafter. I do remember that in Jan 2017 the HR Director under the Maintaining Higher Professional Standards (MPHS) (a requirement to have this as an agenda item) informing of a consultant who had been excluded from practice. The Medical Director normally confirms due process is being followed and a Case Manager and a Case Investigator had been appointed. Normally NEDs or I would not at this stage ask any questions due to the investigation process and the Medical Director would normally confirm that the early alert had been informed to the Dept.

Where Shane Devlin states I questioned him on his review I must stress that Shane undertook a comprehensive review of all aspects of Trust Governance which included C&SCG without informing me or any other NED in advance and without bringing it to the Board. I will deal with this later in my answers.

Received from Roberta Brownlee on 29/11/2022. Annotated by the Urology Services Inquiry

undermined by the Chair as she often chose to interact directly with the members of SMT outside of my knowledge."

Please comment on what Mr. Devlin states in this paragraph indicating in which respect(s) you agree or disagree with it, and why? Please provide examples and all relevant details.

I was shocked to read these comments by CX Shane Devlin. I was under the impression that I had a very good working relationship with Shane. I never once recall "clashing with him" as he refers. We had many meetings formally and informally. We walked the sites on occasions and had many cups of coffee together. We talked often of his children and their progress through university and school. Shane Devlin and his wife attended a formal Charity function as guests of mine. I strongly refute that I did not have a good working relationship with him. We agreed to differ on some occasions, but this was professionally and respectfully done.

If Shane believed our relationship to be a difficult one, it certainly was not made apparent on any occasion. We had many Board Development Days where we met to discuss the functioning of the Board and our relationships. I fostered an open, transparent and honest culture and wanted the environment to be one where members could discuss and resolve any issues between themselves.

As Shane rightly says, there had been some 'lack of consistency in personnel in the Chief Executive post' and associated instability. I felt that my position as a long-standing Chair provided much needed stability for the NEDs, and I had built very good professional relationships with them. This is what Shane was unsettled by.

I found Shane Devlin to be a strong confident CX and certainly would not have expected him to hold back in challenging me if he felt I was overarching or unhelpful. I append the 2018/2019 360 feedback form provided by Shane Devlin (Exhibit RB-05). You will note that his assessment of me in role as Chair was uniformly either 'very effective' or 'effective' – the two highest scores.

Received from Roberta Brownlee on 29/11/2022. Annotated by the Urology Services Inquiry

has to be across the piece of the Board. I invite our Operational Directors to be a part of the conversation as well, and I see that coming through over the last couple of years.

38 Q. We are going to look at Board training in a moment, but just on that point that you have mentioned about, you felt that the skill mix was sufficiently robust for curiosity to be generated, just as a broad point: Do you have any view as to why people perhaps weren't more curious about information that was brought then, if the skill mix would have allowed that, why perhaps more questions weren't asked when certain information was brought to the Board and it doesn't seem that there was any desire to interrogate it in any robust way, do you have any view on that? 10:39 10:40 10:40

A. I do. My observations, both as a Non-Exec and now in the position of Chair, there appears to be this view that when you get into the boardroom the questions only come from Non-Executive Directors, that the Board is Non-Executive Directors. That is not the case. The Board is made up of 13 individuals with other Operational Directors being a part of that discussion. So there's a long held way of working where the people responded to questions and didn't think they had a place to ask a question. What I have attempted to do in the time that I have been in post as Chair is to create that environment and allow our executive directors and Operational Directors to know that they have a voice at that table too and to use it. I'm 10:40 10:41

seeing that happening more and more over the recent years. So I think it boils down to a way of working that has been ingrained for a long period of time and the thought process that we are there to respond. Some of the language that was used, that is used actually in the terms of reference, you know we talk about scrutiny, we talk about challenge, that is interpreted as we sit and wait till we are asked a question rather than thinking I have a role to do that too. 10:41

39 Q. So can I take from your answer that it's two-fold really: Promoting and encouraging confidence and confidence building and also fostering the correct cultural environment that people feel able to ask and be curious without thinking that they are either inappropriately asking or asking a question that they shouldn't? 10:42 10:42

A. And if I may add a third one: Reminding executive directors that they are executive directors of the Board. So when we make a decision as a Board, it's making a decision, 13 people are saying this is the path, so they have to be involved in that discussion. 10:42

40 Q. Now, when we look at Board training and we go to your statement at WIT-100443, at paragraph 8.1 you say:

"The Non-Executive Chair is responsible for identifying and organising training for board members. Non-Executive Directors also have a personal responsibility to identify training needs at least annually through the appraisal process." 10:43

Trust area and the legacy trust. She is constant, she was a constant individual for the Southern Trust. When you look at the flux of the senior executive and the Board, Roberta Brownlee was the constant person that was there. So either rightly or wrongly the stepping from the Chair to the Chief Executive role, you can see how easily that was for Roberta Brownlee to do and that she felt, I would suspect she probably felt that she needed to step in at that flux period. But that flux created that space that allowed Mrs. Brownlee then to become in essence what I have referred to in my statement as a de facto Chief Executive when we didn't have a substantive Chief Executive in post. 12:47 12:47

117 Q. We will look at Mrs. Brownlee later on in relation to her involvement on the Board. I just want to briefly touch on the urology departments being flagged up or being raised at Board level. A couple of these are before your time so I won't take you to them because you can't speak to them, but I am going to give those examples just for the Panel's note? 12:48 12:48

A. Okay.

118 Q. The first one is 2009 when the Trust Board was made aware of the ongoing capacity issues in urology and the related impact on patient waiting time, an example of that Trust Board is at TRU-105665 which is 24th September 2009. The minutes state that the Trust Board was advised that the trusted had undertaken a review of urology services and this had highlighted a capacity gap. 12:49

	Examples include: • Trust SMT weekly has a standing item for clinical governance which may take 30-45 minutes' discussion per meeting. Additional discussions regarding specific clinical governance issues may range from 1-1.5 hours. • 1-1's with my senior team, in particular my executive professional directors and operational directors, will have 60-70% of time discussing these matters. • Trust Governance Committee agenda is regularly 70% discussion of clinical governance issues. • Trust Board agenda is regularly 60% discussion of clinical governance issues.

Q21	**How do staff generally inform you about or engage you in conversations regarding clinical governance issues? Is it your usual experience that they generally do so informally, or in writing, or both?**
Response	Staff can inform and engage me in conversations regarding clinical governance issues via a variety of means, this may be verbally or through formal written submissions. Examples include: • Via indirect ongoing engagements with my Director leadership team who relay communications to me via email, telephone, meetings or as required in person. • Clinical staff are also able to, and do, contact me directly where an issue of concern may have arisen; this occurs predominately via email. Recent examples have included a senior Orthopaedic consultant raising concerns with regards to his inability to operate as resources had been consistently redirected to Intensive Care to support Covid19 patients, a senior Medical consultant concerned about lack of investment in middle grade doctors in his wards and a radiographer concerned about the balance of workload across sites. In all cases I will engage to listen and try to address the issues raised. • I also undertake chief executive visits to speak directly with clinical staff and patients to gain an understanding of the issues and pressures that occur at the point of care. Leadership walks are conducted by myself, senior team members and other Trust Board members. These take place across all sites and locations of care in and out of normal working hours. • The Trust operates a Whistleblowing policy. We recognise that many issues are raised by staff and addressed immediately by line managers, which is encouraged. This policy and procedure is aimed at those issues and concerns which are not resolved, require help to get resolved or are about serious underlying concerns. • I have an open door policy and any members of staff can, and do, meet with me. In my tenure I have had two situations where senior clinicians have confidentially alerted me to areas of serious management and governance concerns. One was with regards to concerns about a Director's performance (reference question 6) and the other was about safety concerns in a surgical specialty Both of those were able to be addressed.

Q22	**How would you describe the methods which you deploy to ensure that you get to know that what is expected of people in terms of compliance with clinical governance standards and arrangements is actually being carried out?**
Response	As described before, the Trust operates multi-stranded assurance reporting regarding compliance with clinical governance standards and arrangements, examples of the assurances obtained by myself and Board members include: • Quarterly reports to Trust Governance Committee which include information on adverse incidents, serious adverse incidents, clinical standards and guidelines and complaints management

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

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

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

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

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

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

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

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

What is your view of the efficacy of these systems?

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

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

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Clinical Record Reviews have deepened our awareness of the extent of the problems.

iv. That said, the governance processes that were in place at that time did not capture the difficulties adequately to recognise the risks to patient safety. Arguably the only person who was fully cognisant of Mr O'Brien's practice at that time was Mr O'Brien and he did not raise these concerns to his medical or operational line managers.

v. In addition to this, when concerns were raised in the past it appears to have been difficult for Trust clinicians and managers to have felt supported or taken seriously in dealing with the challenges presented by Mr O'Brien. This then seems to have engendered a culture of deference, acceptance and silence. If these staff had been more fulsomely supported and the information they presented triangulated this may have addressed these concerns at an earlier stage.

vi. As outlined in previous answers when I arrived in the Trust from January 2019 onwards I worked to strengthen Corporate Clinical and Social Care Governance. As a result, I commissioned a review through the Chief Executive of CSCG and have been implementing the Action Plan from this that was developed in Autumn 2019 and throughout the course of the pandemic (which has delayed its implementation).

vii. In addition to this, I have introduced improvements into the system of Professional Governance through Appraisal and Revalidation processes and the oversight of doctors and dentists in difficulty and medical leadership development.

viii. As Chief Executive I am in the process of restructuring Operational Directorate structures to strengthen clinical and social care governance and further increase the focus on patient safety and developing mechanisms to support freedom to speak up and whistleblowing.

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Risk Register	Risk Number	Actions
Corporate Risk Register February 2016	Risk No 2 Outpatient review and planned treatment backlogs	Internal resources continue to be directed to increase capacity for consultant review activity as this becomes available. Further non recurrent funding allocated for Quarter 3 & 4
Corporate Risk Register 07th September 2017	Risk No 14 Clinical risk associated with inability to see urgent/red flag patients within clinically indicated timelines	Non recurrent funding as available will be allocated to provide additional activity to address the risk to patient safety associate with inability to manage patient care within clinically indicated timescales. The Trust will continue to redirect any available internal resources to areas of greatest risk.

29.5 Reflecting back on my tenure from 2016, I do not believe that the patient safety risk associated with the demand:capacity mismatch and delays in access to services was as explicit in the early part of my tenure as it has been in recent years. As the Inquiry is aware, the demand:capacity mismatch has been intensifying and, as a Trust the Board, I believe that we are now acutely aware of the likely impact on the patient, whether they be a patient waiting in the Emergency Department or a patient on a waiting list for diagnostics. *Please see:*

114. Item 6. Bluestone Dorsy update TB 270918 (3)

115. Item 3. Final confidential minutes - 27.9.2018

116. Item 4i. Bluestone Dorsy revised update TB 251018 (3) Final

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

structure which defines what they're responsible for or not, or if there is a lack of clarity. I think those leading cancer care should be responsible for positive outcomes and negative outcomes in cancer care. Without that clarity, it definitely fell between several stools. Through my interviews with the different staff, you could not get clarity about who actually owned problems. That, in itself, was a problem. 11:59

MR. WOLFE KC: You highlight, whatever else about the other concerns that you picked up on from this MDT and how it operated, you say that there were two issues that you could identify from the information coming your way that were known to the MDT. One was the nursing issue and the second one was the prescribing issue. The prescribing issue was also known externally. You had heard from Professor O'Sullivan, for example, in that respect. 11:59 12:00

Knowledge of those issues isn't enough; you suggested, it has to be escalated. How do you imagine that ought to have been done properly? What would that have looked like? 12:00

DR. HUGHES: Well, proper escalation should have been to Cancer Services then up to the board at the level of Medical Director. If there's concern about prescribing that may or may not affect patient care, I think the simplest answer to that would be to do a proactive audit or prospective audit and define the issue. This should be part of normal business within the MDT 12:00

working. I know these are difficult questions in a team. If the culture in the team is not good, they are questions that can be not had but that's not the point. If somebody is concerned there's prescribing that may affect patient care, they have to take action, they have to escalate it to the appropriate people; they have to understand it and hear it and they need to deal with it or escalate it. That could be through the business meetings. 12:01

I got the impression the culture wasn't good. There wasn't a willingness to escalate these issues and, unfortunately, a full understanding of the issues. I think until you do an appropriate review of the concern, you really don't know the extent of the issues. 12:01

The issue about Clinical Nurse Specialists, that was clearly known by the manager and there's clear documentation of how she had tried to address that through her line of management. 12:01

MR. WOLFE KC: That is Mrs. Martina Corrigan who told you - the reference is WIT-84356 - the issue of nursing was escalated to the Assistant Director and the Associate Medical Director. They never got anywhere, it is suggested. That perhaps suggests that the process for escalation was there and it was used in that instance, but the appetite to force real change was, for whatever reason, not there or not followed 12:02

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

Review Terms of Reference

The Trust has agreed to appoint a project manager on an interim basis for three months.

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

The aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms in relation to:

- The appropriate and timely identification of risks in relation to the safety and quality of clinical and social care.
- The use of adverse incident reporting, 'near misses', risk assessments, complaints and other information sources to inform the identification of such risks.
- The effectiveness of current systems, processes, capabilities and capacity in providing effective management of such risks.
- Systems to ensure that lessons are learned from these internal processes and embedded throughout the Trust.
- Systems to draw and evaluate learning from elsewhere and use this information to assess and where necessary improve safety and quality of care.
- Clinical engagement and involvement in clinical and social care governance systems, processes and assurance mechanisms.
- Processes for ensuring the implementation of standards and guidelines.
- Support to and within Directorates to effectively implement the above.
- The selection, capture, measurement and reporting of safety and quality indicators and information to provide robust assurance to SMT Governance, Governance Committee and Trust Board on the safety and quality of Trust services.
- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for clinical and social care governance.

The Project Manager will undertake a process of in-depth engagement with key stakeholders to ensure this assessment of

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

effectiveness is robust, and to ensure ownership for any associated recommendations for improvement. Part of this engagement process will be the establishment of the 'Virtual Clinical and Social Care Governance Team' as to act in support of the Project Manager and as a key stakeholder group.

This assessment and engagement process will inform the Project Manager's recommendations to SMT Governance in relation to current and planned future clinical and social care governance arrangements, and will complement and integrate with the development of an action plan which ensures the findings and learning from the report into Mid-Staffordshire NHS Foundation Trust are implemented within the Southern Trust.

This assessment, recommendations and action plan will be presented to SMT Governance by the end of June, with updates on progress being provided on a monthly basis for the duration of the Review.

The project manager will report to the Chief Executive for the duration of the project.

March 2010

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Re-visit of Governance

Domain	Update
Review of Adverse incident Processes	• Staff Training Sessions on Adverse Incident review have taken place • Classification and Trending of Serious Adverse Incidents • Review of SAI's against national baseline • Trustwide review of incident management processes commencing in June 2016 (HSCB & DHSSPSNI included)
Complaints Management	• Complaints coding taxonomy developed • Classification and Trending of complaints data (OPPC & CYPS directorate pilot) • Regional discussions regarding adaption of Trust framework
National Audit	• National Audit programme for 2016/17 mapped and agreed by SMT based on UK wide definitions • Framework process for Trust management of National Audits developed
Standards & Guidelines	• Work to develop a single reporting system underway • Review of current S&G compliance status in progress
Mortality & Morbidity	• Implementation of Child Death notification system • Regional Mortality and Morbidity Reporting System due for pilot August 2016

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Use of Indicators

*"**Indicators are measurement tools, screens, or flags** that are used as guides to monitor, evaluate, and improve the quality of patient care, clinical support services, and organisational function that affect patient outcomes"*

Canadian Council on Health Services Accreditation. A guide to the development and use of performance indicators. Ottawa: Canadian Council on Health Services Accreditation, 1996.

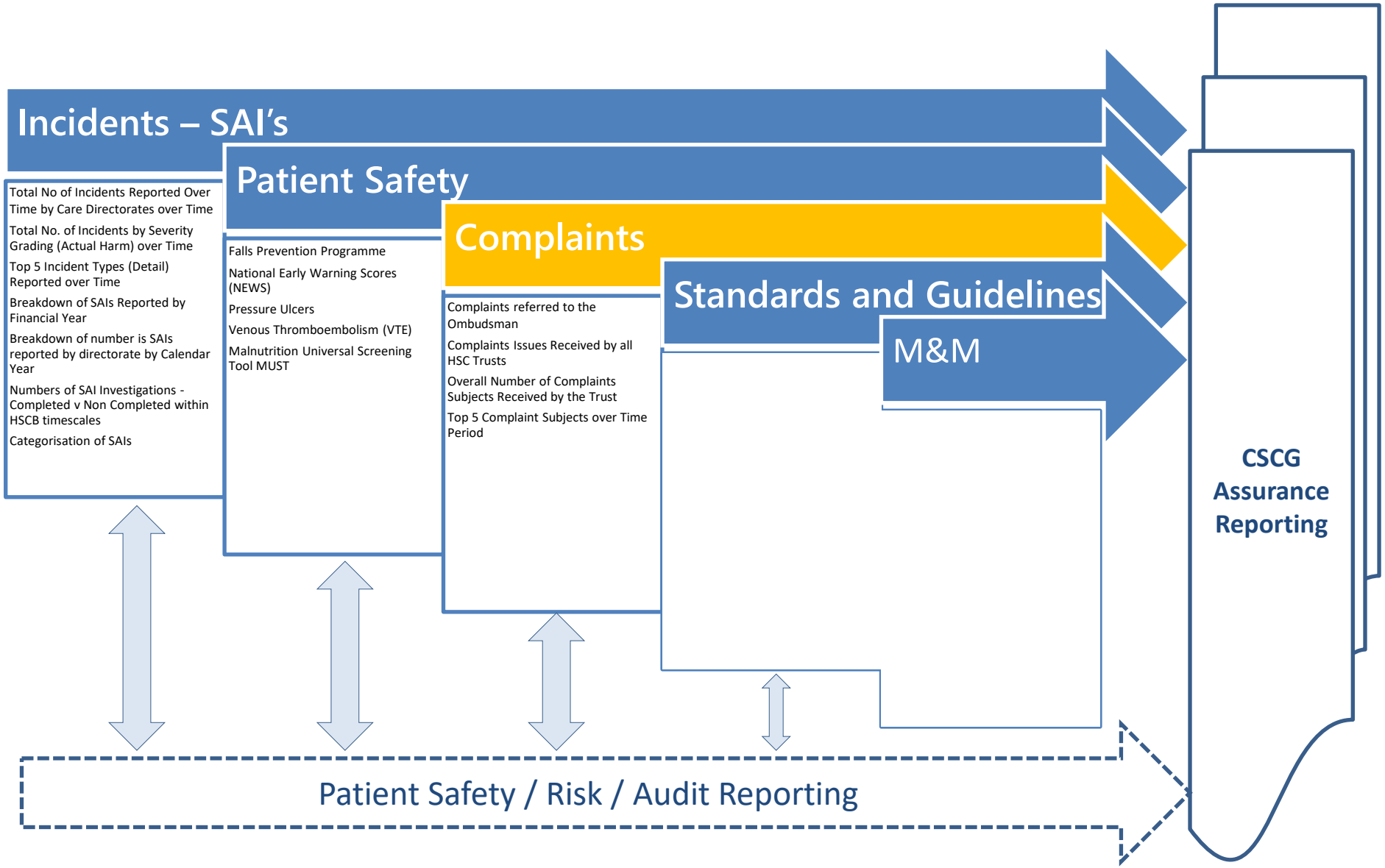
Both Process and Outcome Indicators

Indicators used to prompt further investigation

Indicators used to drive quality improvement

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Corporate CSCG Reporting Arrangements



Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry



Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Southern Health and Social Care Trust

Quality Care - for you, with you

Clinical and Social Care Governance Re Visit

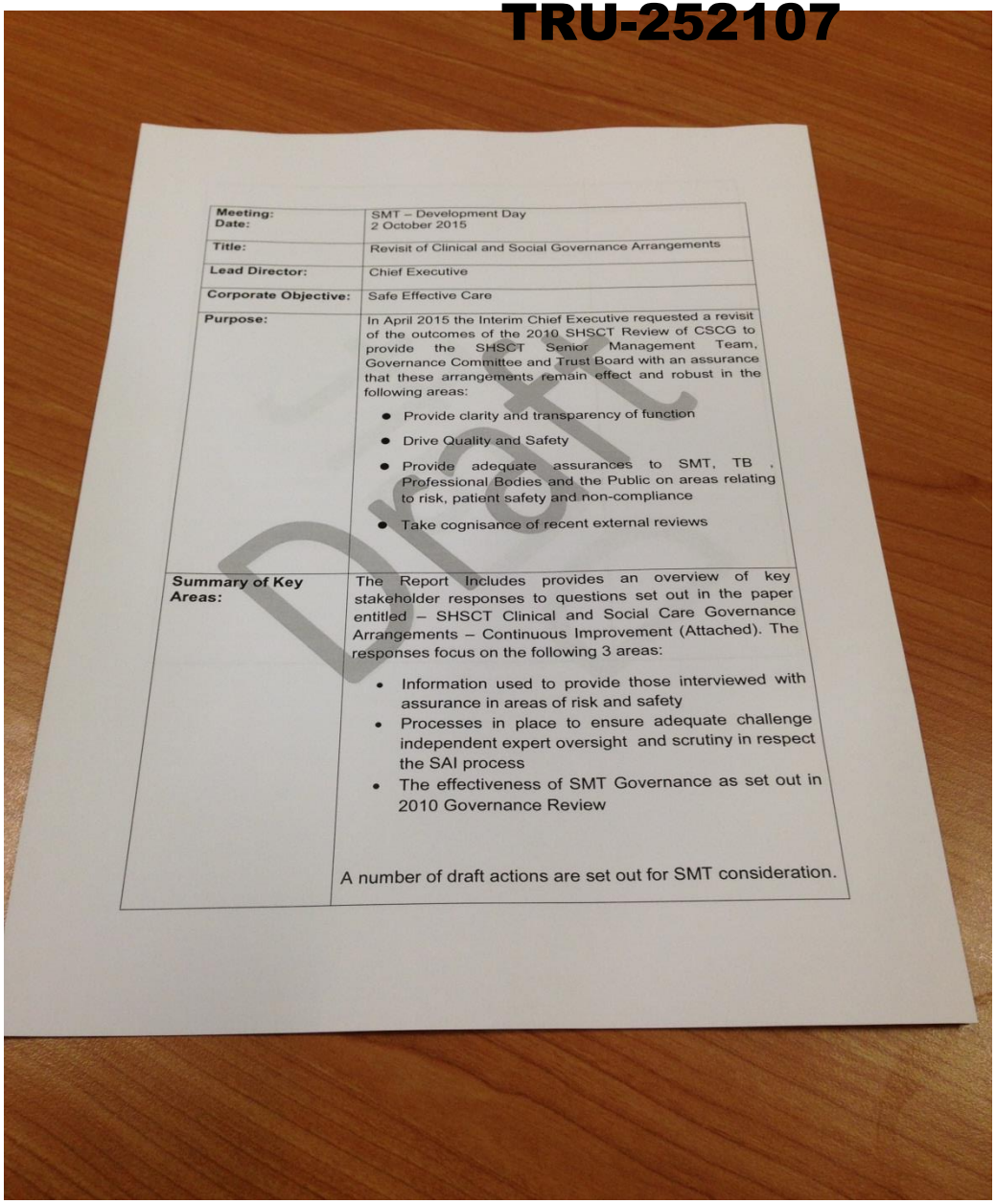
An Opportunity to Improve Integrated Governance Framework

SMT Away Day 2nd October 2015

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

High level feedback on findings/views form the revisit exercise

- Appetite for taking forward
- Defining priorities
- Prioritisation/ Timescale



Meeting: **Date:**	SMT – Development Day 2 October 2015
Title:	Revisit of Clinical and Social Governance Arrangements
Lead Director:	Chief Executive
Corporate Objective:	Safe Effective Care
Purpose:	In April 2015 the Interim Chief Executive requested a revisit of the outcomes of the 2010 SHSCT Review of CSCG to provide the SHSCT Senior Management Team, Governance Committee and Trust Board with an assurance that these arrangements remain effect and robust in the following areas: • Provide clarity and transparency of function • Drive Quality and Safety • Provide adequate assurances to SMT, TB , Professional Bodies and the Public on areas relating to risk, patient safety and non-compliance • Take cognisance of recent external reviews
Summary of Key Areas:	The Report Includes provides an overview of key stakeholder responses to questions set out in the paper entitled – SHSCT Clinical and Social Care Governance Arrangements – Continuous Improvement (Attached). The responses focus on the following 3 areas: • Information used to provide those interviewed with assurance in areas of risk and safety • Processes in place to ensure adequate challenge independent expert oversight and scrutiny in respect the SAI process • The effectiveness of SMT Governance as set out in 2010 Governance Review A number of draft actions are set out for SMT consideration.

Draft

Rose Review 2015 – Better Leadership for tomorrow NHS Review

I recognise that the NHS is immensely complex, and that one apparently straightforward recommendation will have many implications and perhaps unintended consequences; but because we are intimidated by complexity and scale there is equally a danger of doing nothing. The way to handle complex matters is to simplify them wherever possible. It is a risk we should take'.



Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry



Agree – Practical Actions

Achievable within present Clinical and Social Care Governance Arrangements

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Why Now?

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Journey of Clinical and Social Care Governance 2010 - 2015

- 2010 – 2013 – embedding of operational governance arrangements
- 2013 – 2015 – extreme external focus on governance 6 independent reviews in 18 months and public inquiry
- Time and resource at corporate level and operationally focused on look back exercises and external reviews
- Continuous Improvement 'paused'
- Time to develop, improve, strengthen, explore connectivity and integration of elements CSCG to inform quality and improvement
- Review effectiveness of the Board Assurance Framework

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SHSCT Learning – Public Inquiry into Hyponatraemia Related Deaths – Governance Segment

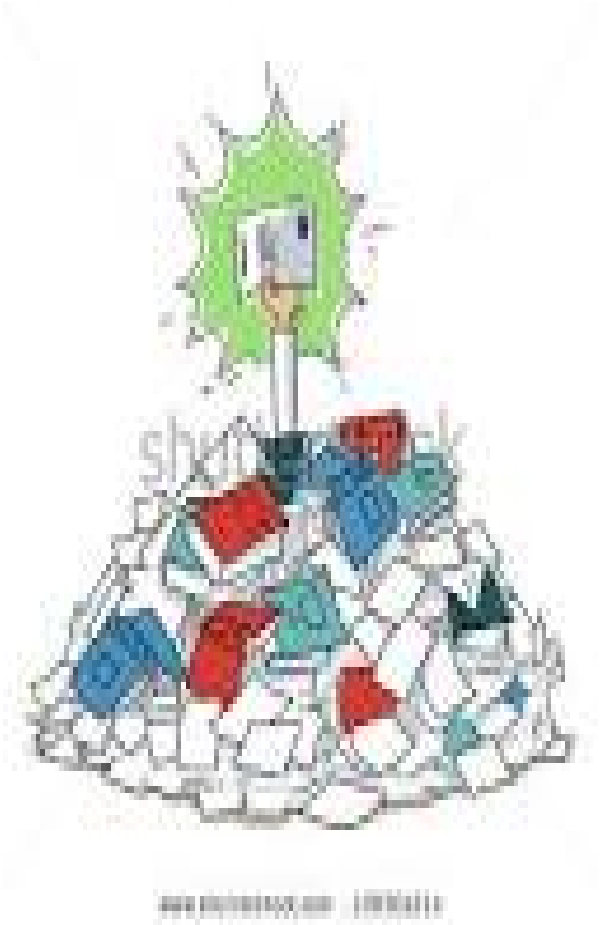
- Failed to ensure that the Departmental guidance issued in March 2002 was properly disseminated, implemented and monitored by the Trust. (CX, MD (1), DN (1))
- Failed to take appropriate steps to assure yourself that the Departmental Guidance had been made the subject of training throughout the Trust.(MD(1),DN(1))
- You should have ensured that a local protocol was developed to complement the guidance and provided more specific direction to junior staff.(MD (1),DN(1))
- You should have audited compliance with the guidance and your locally developed protocol and learned from clinical experience. (MD (1),DN (1))
- You should have recognised that the 2002 Guidelines had not been disseminated to all relevant clinical areas and had not been implemented or audited effectively. (MD (2) ND (2))
- You missed an opportunity to rectify any deficiencies in the Trust's response to the Guidelines. (MD (2) ND(2))

3 Key Areas within TOR – Re Visit of CSCG 2015

- Information you receive to provide you with assurance
- Mechanisms in place to provide independent expert oversight, challenge and scrutiny in respect to learning from SAI's
- The effectiveness of SMT Governance as set out in 2010 Governance Review

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Information you receive to provide you with assurance



- Change presentation of information
- Agree a CSCG audit plan linked to key safety priorities
- Introduce a CSCG Dash Board
- Support the Dash Board with:
  - Narrative on improvement
  - Controls in place where risks identified
  - Patient experience
  - Staff feedback through e.g. CSCG training evaluations

Next Steps

Agree indicators

Test with SMT re effectiveness

Timescale for implementation – (Dependent on capability of systems) January 2016

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Example – SMT - CSCG Dash Board

Title	Indicator	Performance %	Controls in place	Improvement Plan
Complaints Management	Numbers of Complaints Received			
	% complaints responded to within 2 days Target 100%			
	% complaints responded to within 20 days Target ????			
	% to Ombudsman (support with narrative) % Upheld			
	1 example compliment and complaint per directorate monthly (Patient Experience)			
	Training activity report 3 monthly (Staff)			

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Title	Indicator	mance %	place	nt lan
Serious Adverse Incidents	Numbers of SAI reported by level and directorate Narrative – risk /control measures and immediate learning and action			
	% of SAI reported to HSCB with 72hrs (non Tareget 100% (non -compliance explained)			
	% of SAI investigations completed within HSCB timescales Target ???? (Risk learning not actioned)			
	% of families informed of investigation within Target ??? (non compliance explained)			
	% of SAI report shared with families on completion Target 100% (Non compliance explained)			
	SAI Training activity report 3 monthly (Staff)			
	Breakdown of Trends (? Frequency monthly)			
	Implementing recommendations eg: embedded in quality improvement initiative, incorporated into an existing work stream, barriers to implementation			

TRU-252116

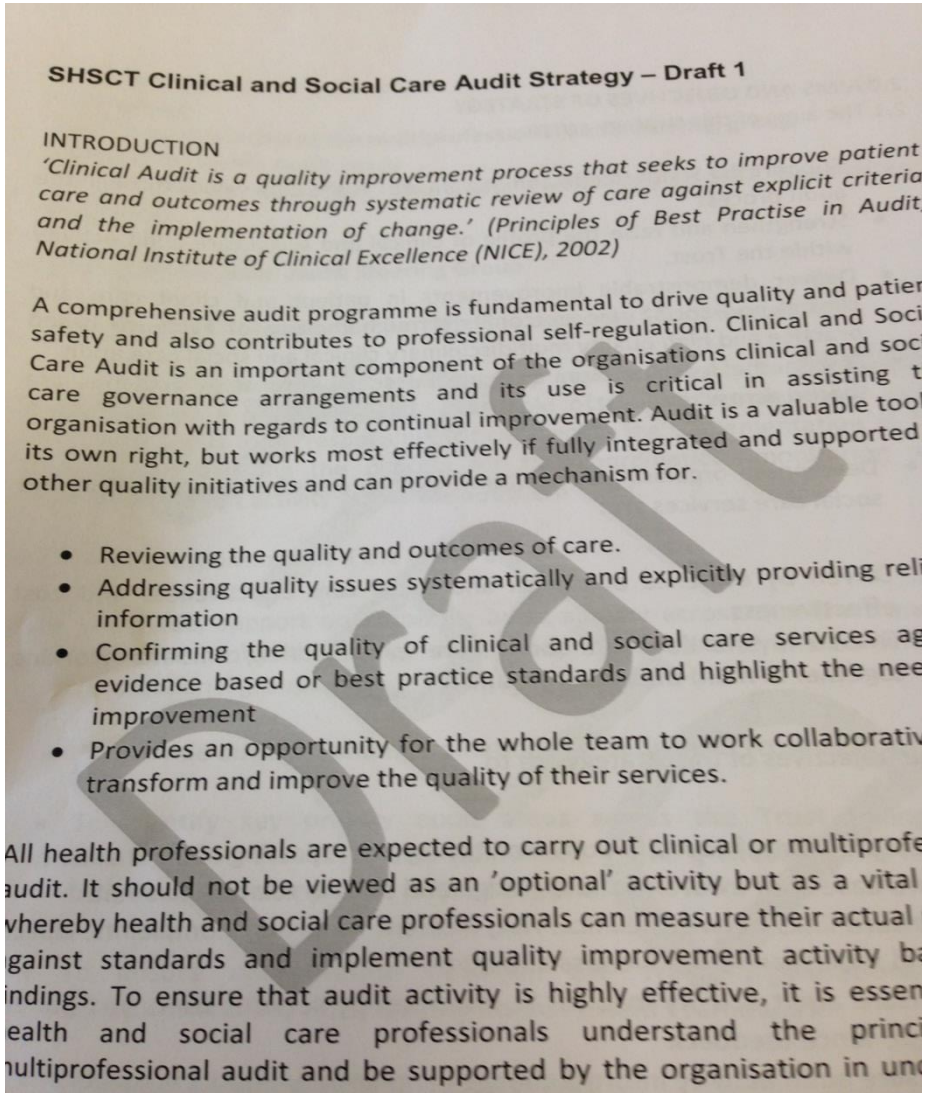
SCT on 21/12/2021. Annotated by the Urology Services Inquiry

Title	Indicator	nce %	in place	ent Plan
Standards and Guidelines	Number of Guideline received per month % disseminated by SG Group with 2 weeks per Directorate Target 100%			
	% of SG received with cross directorate applicable (complex implementation)			
	% of SG with Change Lead identified and confirmed within 20 days of dissemination Target 100%			
	% of baseline assessments t compliance completed with 3 months of dissemination (Early ID issues/risk)			
	% of SG fully complaint within 9 months of dissemination (Non compliance to target identified, controls, improvement plan (target to be agreed)			
	% of SG reported as complaint independently audited (who, how % target)			
	Corporate SG accountability report 6monthly Target 100% Timely			

TRU-252117

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Audit as a Means of Assurance



SHSCT Clinical and Social Care Audit Strategy – Draft 1

INTRODUCTION

'Clinical Audit is a quality improvement process that seeks to improve patient
care and outcomes through systematic review of care against explicit criteria
and the implementation of change.' (Principles of Best Practise in Audit
National Institute of Clinical Excellence (NICE), 2002)

A comprehensive audit programme is fundamental to drive quality and patie
safety and also contributes to professional self-regulation. Clinical and Soci
Care Audit is an important component of the organisations clinical and soc
care governance arrangements and its use is critical in assisting t
organisation with regards to continual improvement. Audit is a valuable too
its own right, but works most effectively if fully integrated and supported
other quality initiatives and can provide a mechanism for.

- Reviewing the quality and outcomes of care.
- Addressing quality issues systematically and explicitly providing reli
  information
- Confirming the quality of clinical and social care services ag
  evidence based or best practice standards and highlight the nee
  improvement
- Provides an opportunity for the whole team to work collaborativ
  transform and improve the quality of their services.

All health professionals are expected to carry out clinical or multiprofe
audit. It should not be viewed as an 'optional' activity but as a vital
whereby health and social care professionals can measure their actual
gainst standards and implement quality improvement activity ba
indings. To ensure that audit activity is highly effective, it is essen
ealth and social care professionals understand the princi
ultiprofessional audit and be supported by the organisation in un

Draft

- Gap identified organisation audit plan—internal audit and NED's
- CSCG Audit Framework (Draft 1)
- Lead Director
- Reporting schedules into Governance Committee, TB.
- Link the CSCG dashboard /QI framework

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

independent expert oversight, challenge and scrutiny in respect to learning from SAI's



Stakeholders identified gap.

How do we address?

- New forum reporting to SMT ?
- Monthly SMT Focused on Governance?
- Steering Group – QI Framework?

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry



Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

HSC Leadership Centre
Providing Management and Organisation Development

Investigation into issues raised by Dr Donal Duffin and other medical staff colleagues.

Eamonn Molloy
Associate Consultant

17th October 2017



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Introduction

The Southern Health and Social Care Trust commissioned the HSC Leadership Centre, to undertake an investigation into a number of issues which were raised by Dr Donal Duffin.

Dr Duffin spoke at a Trust Board meeting, held in public, in late April; and produced a dossier of information calling into question the Trust's support for the services in Daisy Hill Hospital. In particular, he raised concerns that the Trust was favouring Craigavon Area Hospital by applying higher pay rates for staff in Craigavon, and not applying those same rates to staff in Daisy Hill Hospital in Newry thus exacerbating recruitment difficulties in Daisy Hill. In addition he also raised issues in respect of how the Trust deals with reported risks.

The Trust produced a response to the issues raised, but Dr Duffin was not satisfied with the detail or content of the response.

The Centre was requested to investigate the issues raised, and to produce a report on the findings.

Methodology

In turn, the Centre commissioned Mr Eamonn Molloy, an Associate Consultant, HSC Leadership Centre and former HSC Director to undertake this assignment.

Mr Molloy met with the then Interim Chief Executive, Mr Stephen Mc Nally on the 13th June 2017 to clarify the terms of the brief.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

It was suggested, in order to progress this assignment satisfactorily, that Dr Duffin should be interviewed as a first measure and that this should provide the necessary information to elicit his views on the issues he raised together with the responses received to date.

During the discussions with Mr Mc Nally and Dr Duffin the names of a number of consultant staff were also mentioned as individuals who may have a contribution to make.

Each of these was followed up in turn, with the exception of those who were not direct employees of the Trust.

For the purposes of this report, it was agreed that the findings should be presented thematically and where possible the contributions of individuals should be not be attributed.

Findings:

Management of Risk:

Dr Duffin raised a number of concerns in respect of how the Trust manages reported risks within the organisation. He stated that he and a number of his colleagues have no faith in the current processes as frequently the incident reports are amended without recourse to the report originator. He also stated that the Datix system (the primary computerised system used for the management of risk) was difficult to

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use and very time consuming.

The majority of the clinicians interviewed stated that this was the case and cited this as the main reason for their dissatisfaction with the Risk management processes and systems.

In addition, a number reported that their perception of the prevalent organisational culture was not geared to learning or service improvement; rather than to apportion blame when things go wrong.

On inspection of the cultural survey (Measuring and Enhancing a Safety Culture), which was recently undertaken, thankfully, this perception is **not** borne out.

Indeed the survey reflects a more positive view of how the Trust manages its risk profile including encouraging staff to report incidents and using this information to prevent re-occurrence.

Another issue, which was raised, was in connection with the treatment of the information contained within the incident report particularly relating to the 'severity rating', which is applied by the report originator.

Dr Duffin, and a number of his colleagues, stated that the severity rating, which was originally applied was frequently downgraded by members of the corporate team without discussion or any recourse to the person generating the report. He alleged that this was done to create a more favourable position of the Trust risk profile.

This is his perception. I was informed that there is a review of risk management processes underway at present. (Adverse Incident Project-Strengthening our Response to Adverse Incidents). This review must closely examine how to enhance communication and formal feedback to those staff that take the time to complete an



incident report. This was also evidenced within the aforementioned Cultural Survey, as some 43% of respondents (n820) reported that they never receive feedback on what actions are taken as a consequence of a reported incident.

Without effective feedback, it is difficult to attain learning and in turn, improve safety.

Recommendations:

Consideration needs to be given to the adoption of a formal method of feedback on reported incidents. This is best done within the existing Directorate/Divisional Management teams.

A number of organisations have formalised this process by establishing a ‘Lessons Learnt Committee’ as a visible and tangible link to the incident reporting process. In order to be effective this group needs to utilise the information contained within Datix and regularly receive analysis on the types and trends of incidents occurring. As the name suggests it is important, through this analysis, to translate the information into learning so that any lessons arising are firstly communicated to those who need to know and secondly, to ensure that appropriate remedial actions are taken.

The subject matter contained within the aforementioned Cultural Survey provides a very rich vein of information and sets the agenda for the Adverse Incident Review. It is important to complete the review, as

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quickly as possible and to make whatever modifications are necessary to address any identified areas of concern.

MANAGEMENT ACTIONS IN RESPONSE

Actions:

1. To provide assurance to the Trust's Governance Committee, a retrospective look-back exercise is to be undertaken on incident reports where the severity rating of a report has been amended – this will include Dr Duffin's reports.
2. Each Associate Medical Director to review processes within their teams for feedback to doctors and ensure prospectively that severity ratings can only be amended in consultation with the originator of the report.
3. Establish an Appeal panel where any Clinician dissatisfied with the grading of an incident may seek independent review of this decision. This would comprise at least 1 AMD from outside the relevant service group and a Non Executive Director to ensure openness and transparency regarding the Incident reporting Culture
4. Complete the current review process of the Incident Reporting system taking best practice learning from current regional review of SAIs
5. Establishment in January 2018 of a *Lessons Learnt Committee* to be chaired by the Medical Director to oversee learning from Incidents, Litigation, Complaints, Compliments and National Audits
6. Seek to appoint an ADEPT management fellow for 12 months to specifically develop the 'Lessons learnt' agenda
7. Carry out a prospective Audit of Risk assessment looking specifically at any amended classification within the next 12 months
8. Repeat the Safety Cultural Survey within a year to monitor progress



Communication:

During many of the discussions, the topic of communications was identified as problematic. Almost all of the clinicians, who contributed described communication within Directorate teams as at times ineffective and insufficient for their needs. They believed that their views were not being sought, particularly in relation to key service delivery and operational matters, and the planning of future strategy. The visibility of the Senior Management Team was also described as insufficient.

A number of clinicians described communications between front line staff, Clinical Directors, Associate Medical Directors, Assistant Directors and individual members of the Senior Management Team as inconsistent, with many citing that emails and phone calls remain unanswered.

Whilst it was acknowledged that all of the aforementioned are busy people, nonetheless, it was identified, by all of the clinicians, as an issue that requires to be addressed.

Recommendations:

The respective roles of the AD/CD/AMD need to be clarified and their level of contact with their Directorate/Divisional Teams needs to be enhanced. Many of the clinicians reported that they had not had direct contact with those mentioned above in a considerable time. Directorate/Divisional Team meetings need to be formalised and not left to chance and attendance at these should be recognised as important with due commitment given to them. Where team meetings did occur, attendance was described as sparse and inconsistent.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

The Trust should consider the establishment of a Medical Executive Group, where important service delivery and strategic matters can be discussed with key individuals, in an open and transparent manner. This should also be replicated for the main professional disciplines across the Trust. This will facilitate accurate and timely communication with key staff and increase visibility of the Senior Management Team. The Chief Executive, or a nominated deputy should chair these meetings, and relevant Directors should also be in attendance. This will provide a conduit for the transmission of relevant information to relevant personnel. I understand this is to be taken forward in the very near future.

MANAGEMENT ACTIONS IN RESPONSE

1. Repopulation of the AMD posts (now complete)
2. Filling of Director vacancies with permanent appointments. The permanent Chief Executive post is now filled commencing February 2018
3. Implementation of strengthening of the medical management roles to include two new Deputy Medical Director Roles, one based in each of the acute sites each with a specific remit for governance to improve access of clinicians to on site senior medical managers and improve senior management visibility.
4. Review of Management Structures to facilitate better communication pathways (underway for completion on commencement of CX)
5. Development of the key communication links between Directors, Assistant Directors, AMDs CDs and Heads of Service
6. Involvement of Trade Union Side and community representatives alongside management in the DHH Pathfinder project which has been developed in response to serious risks identified by staff



Perception of 'Craigavon Centric':

Many of those who contributed to this exercise described the Trust as 'Craigavon Centric' in its approach.

It will come as no surprise that this perception was particularly prevalent from those who work primarily in DHH.

Conversely, it was also stated from a number of clinicians working primarily in CAH that they believed that the Trust paid too much attention to DHH rather than CAH.

What was apparent, from the discussions is that these perceptions emanated largely from clinicians working in specialities where there is limited or no cross-site working. The establishment of a Medical Executive Group many create the opportunity for the Trust to better explain the strategic intent and operational out workings of the Trust's business decisions and in turn, help to eliminate the potential for a "them and us" perception.

Dr. Duffin, in particular, provided information on differential pay rates being applied to locum staffing in support of his view of this issue. This was addressed in correspondence between Mr McNally, then Interim Chief Executive, and himself, dated 5th May 2017 and in my view this provides a satisfactory explanation to the point raised.

However, what is disappointing and potentially damaging is that this perception exists at all.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Recommendation:

The Trust should enhance its direct communication with its medical workforce and should establish the suggested Medical Executive Group, if this is accepted.

The Trust should endeavour to promote and actively encourage cross-site working, where possible, to reduce the perception of the Trust favouring one site or the other.

MANAGEMENT ACTIONS IN RESPONSE

1. Re establishment of the Clinical Leads Forum or Medical Executive on a regular basis. This would meet at least 3 monthly and be led and chaired by the new Chief Executive.
2. Continue work of 'Cross Site Working Group' established with LNC to ensure that geographical barriers do not prevent adoption of best practice models
3. Implementation of the DHH Pathfinder recommendations

Organisational Structures:

Many of those interviewed stated that there was a lack of visibility of the senior executive team at Divisional level.

This is not an uncommon view within the province, even though most if not all Trust senior teams find this difficult to accept.

The organisation, direction and effective operation of a busy HSC Trust always has the potential to consume individual members or all of the senior executive team into their primary Headquarters, thus reducing the amount of time that they can spend at Divisional, ward or facility level.



Each Trust approaches this differently and it would be inappropriate to be prescriptive about the best method to address this concern. Suffice to say, it has been raised and every opportunity should be taken to enhance the visibility of the senior team.

Perhaps more importantly, another issue, which was raised in relation to organisational structure, centred on the respective roles of the Associate Medical Director, Clinical Director and the Assistant Director.

There was a variation of opinion expressed in relation to this matter ranging, from a very positive description of these roles and the interaction between them; to an expressed distinct lack of clarity of "who does what" leading to what was described as ineffectiveness and dysfunction.

It was clear, however, that there is inconsistency across the Trust relating to this group and this requires to be addressed.

Recommendations:

I understand, that there have been recent personnel changes amongst these categories of senior staff. This may provide the opportunity to clarify the respective roles of each and the Trust's expectations of them as a team at Directorate or Divisional level.

They are an extremely important and integral aspect of the Trusts operational management team and it may be timely to facilitate some development activities to address the above.

One additional issue, which was raised in all of the discussions, concerned the requirement to recruit and fill the position of the Chief Executive.

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It was recognised that despite the best efforts of those who have held the position in either, an acting or interim basis, the delay in filling this key post has been unacceptable and has led to instability.

I understand that the recruitment exercise is now underway and this is to be welcomed.

MANAGEMENT ACTIONS IN RESPONSE

As above

Specific Clinical Issues:

During the course of these discussions a number of specific clinical issues were raised. These will be appended to this report as an addendum as they refer to specific issues with a clinical setting.

Conclusion:

This report has been written to record concerns, which were expressed by fifteen members of medical staff at consultant level.

These clinicians were from a number of different specialities and work in either Craigavon Area Hospital or Daisy Hill Hospital.

Whilst this cannot be stated to be absolutely representative of the views of all staff, nevertheless there is a correlation in respect of the issues raised particularly relating to the importance of effective communication, the management of risk, limited cross Trust working and the effectiveness of current Organisational structures.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

The views expressed by colleagues have been presented thematically in this report and, where possible, I have made suggestions of potential measures to remedy some of the concerns raised.

These can be considered by the Trust in due course.

Acknowledgement:

I would like to acknowledge the contribution of each of the members of medical staff, all of who expressed a genuine desire to clearly state their views primarily, to improve patient care and to improve working relationships within the Trust.

I would also like to acknowledge the contribution of members of the senior executive team for giving up their time during a very busy period of the Trust's operating cycle.

I remain available to provide any further information if required.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

ACTIONS IN RESPONSE TO WHISTLEBLOWING REPORT

THEME 1 MANAGEMENT OF RISK

MANAGEMENT ACTIONS IN RESPONSE

Actions:

1. To provide assurance to the Trust's Governance Committee, a retrospective look-back exercise is to be undertaken on incident reports where the severity rating of a report has been amended – this will include Dr Duffin's reports.
2. Each Associate Medical Director to review processes within their teams for feedback to doctors and ensure prospectively that severity ratings can only be amended in consultation with the originator of the report.
3. Establish an Appeal panel where any Clinician dissatisfied with the grading of an incident may seek independent review of this decision. This would comprise at least 1 AMD from outside the relevant service group and a Non Executive Director to ensure openness and transparency regarding the Incident reporting Culture
4. Complete the current review process of the Incident Reporting system taking best practice learning from current regional review of SAIs
5. Establishment in January 2018 of a *Lessons Learnt Committee* to be chaired by the Medical Director to oversee learning from Incidents, Litigation, Complaints, Compliments and National Audits
6. Seek to appoint an ADEPT management fellow for 12 months to specifically develop the 'Lessons learnt' agenda
7. Carry out a prospective Audit of Risk assessment looking specifically at any amended classification within the next 12 months
8. Repeat the Safety Cultural Survey within a year to monitor progress

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

REPORT FROM CLINICAL AND SOCIAL CARE GOVERNANCE IN RELATION TO:

IMPROVEMENTS MADE

IMPROVEMENTS IN PROGRESS

IMPROVEMENTS STILL REQUIRED TO BE IMPLEMENTED

March 2024

Received from SHSCT on 05/03/2024. Annotated by the Urology Services Inquiry.

Introduction

Over the last two years, a significant investment in Clinical and Social Care Governance has been made by SHSCT. This is aimed at improving patient safety, enhancing learning from incidents which did not go as well as planned, improving quality of services and increasing patient and service user involvement.

The level of investment is evident in the attached Organisational Structure. The significant majority of these posts have commenced in the last 2 years. Also, the adoption of the Business Partner model for clinical and social care governance has been effected during this time.

Set out below are the improvements which have already been made, those which are underway and those which still need to be achieved in relation to:

Reporting to Governance Committee

SAIs and Incident Management

Service User Feedback

Datix Incident Management System

Liaison Service

Patient Safety

Received from SHSCT on 05/03/2024. Annotated by the Urology Services Inquiry.

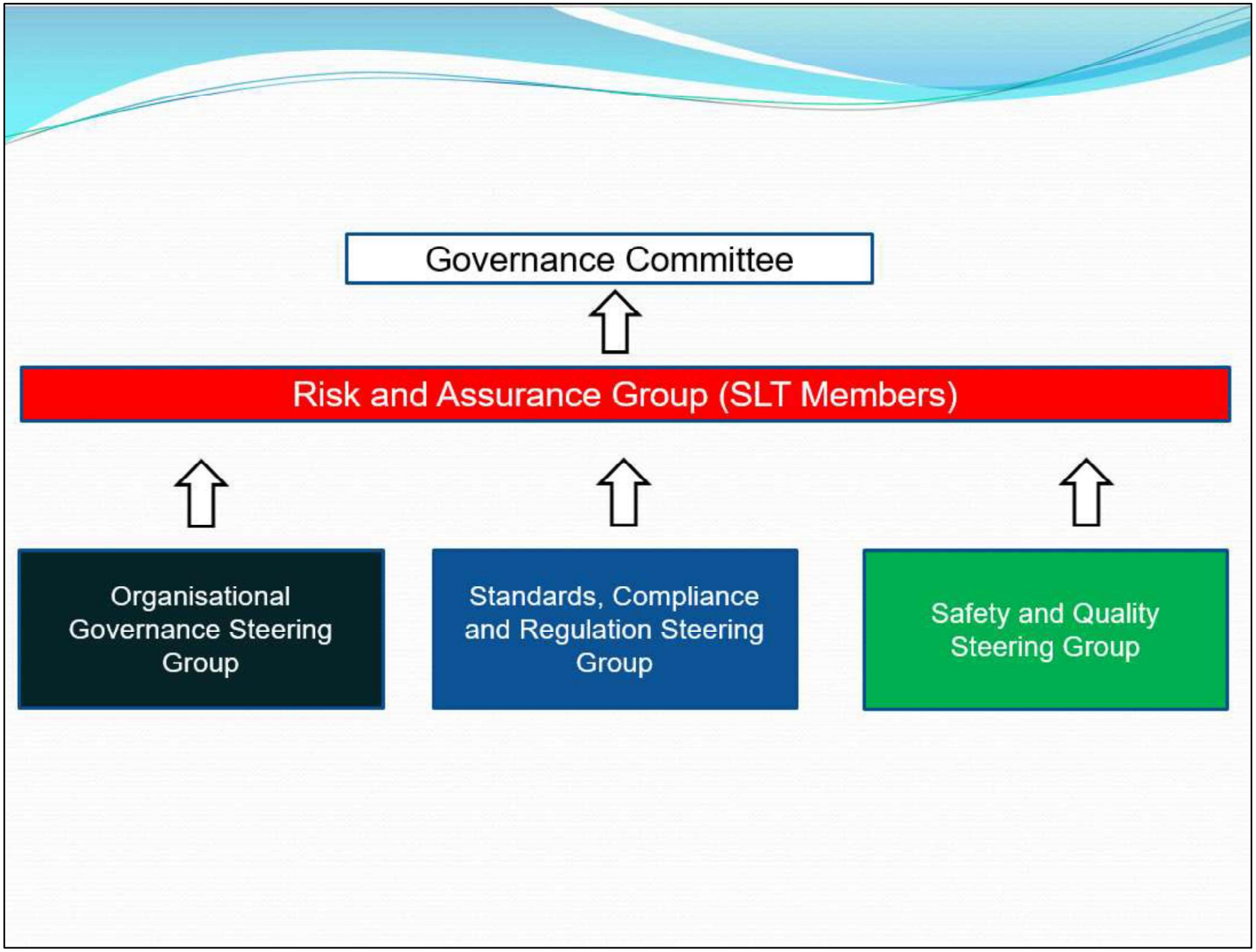
IMPROVEMENTS TO DATE - REPORTING
Enhanced quarterly reporting to Governance Committee
Introduction of a standalone Service User Feedback Report to Governance Committee
Weekly reporting / escalation of issues to SLT
Quarterly Reporting to Safety & Quality Steering Group
Quarterly Reporting to Standards, Compliance and Regulation Steering Group
Introduction of Patient Safety Data & Improvement Team (M&M) Report to Safety & Quality Steering Group
Extended scope of Weekly Governance meeting agenda
Reporting of outstanding Enquiry responses at Weekly Governance meeting
IMPROVEMENTS TO DATE – INCIDENT MANAGEMENT
Development of Datix system for recording, monitoring and reporting of SAI Recommendations
Monthly updates requested on progression of SAIs from Operational Directorate Governance teams, with maintenance of central database
Escalation of SAI progression to AD CSCG as required
Escalation of Overdue SAIs to SLT
IMPROVEMENTS TO DATE – DATIX INCIDENT MANAGEMENT SYSTEM
Datix Upgrade
Development of Datix System for recording, monitoring and reporting of RQIA recommendations
IMPROVEMENTS TO DATE – SERVICE USER FEEDBACK
Quarterly meetings with NIPSO and PCC to assist with progression, oversight and assurance
IMPROVEMENTS TO DATE – LIAISON SERVICE
Extended scope of Liaison Service to support the Urology Lookback Review and Cervical Cytology Review
Extended scope of Liaison Service to support Complex Complaints

IMPROVEMENTS TO DATE – PATIENT SAFETY DATA & IMPROVEMENT
New de-brief form is produced following M&M meetings, highlighting additional information on SAIs and outcomes of discussion and sent to relevant M&M attendees and operational/governance colleagues
Application of the Shared Learning Policy and completion of template has begun following M&M meetings. A quarterly report is produced based on information obtained from regional Splunk reports showing areas and themes for learning
IMPROVEMENTS UNDERWAY – INCIDENT MANAGEMENT
Development of Executive Director Oversight Group – meetings have taken place, ToR being finalised
Development of Trust SAI Policy and Procedure to assist in standardising processes – to be presented at SHSCT Policy Scrutiny meeting 28/03/2024, aim for implementation by April 2024
Development of Incident Management Awareness training package – Corporate Mandatory Training for all staff across the organisation, aiming to go live by 1st April 2024
IMPROVEMENTS UNDERWAY – DATIX INCIDENT MANAGEMENT SYSTEM
Ongoing work by embedded Corporate Governance Datix team on 'Contacts' to facilitate the ability to triangulate Incidents, Complaints and Claims information
Development of standardised Revalidation reports on Datix
Use of Business Intelligence software to triangulate and theme information within Datix across various modules such as Incidents, Complaints and Claims (including Coronial Affairs)
Development of Automated Reporter Feedback in Datix
Review of the Incident Reporting Form on Datix
Inclusion of timeframes for review in Datix and Incident Management Procedure, with escalation pathway
Transition of Complaints module from Datix 'Rich Client' (an older version of Datix) to Datix Web - Work has commenced on this transition, help is being sought from RL Datix to support this work.
Development of standardised datasets for reporting of Complaints from Datix
Transition of Claims module (Litigation services) from Datix 'Rich Client' (an older version of Datix) to Datix Web
As pioneers in developing Datix in the recording, monitoring and reporting of SAI and RQIA recommendations within the Region, continue to promote and share knowledge of this system development

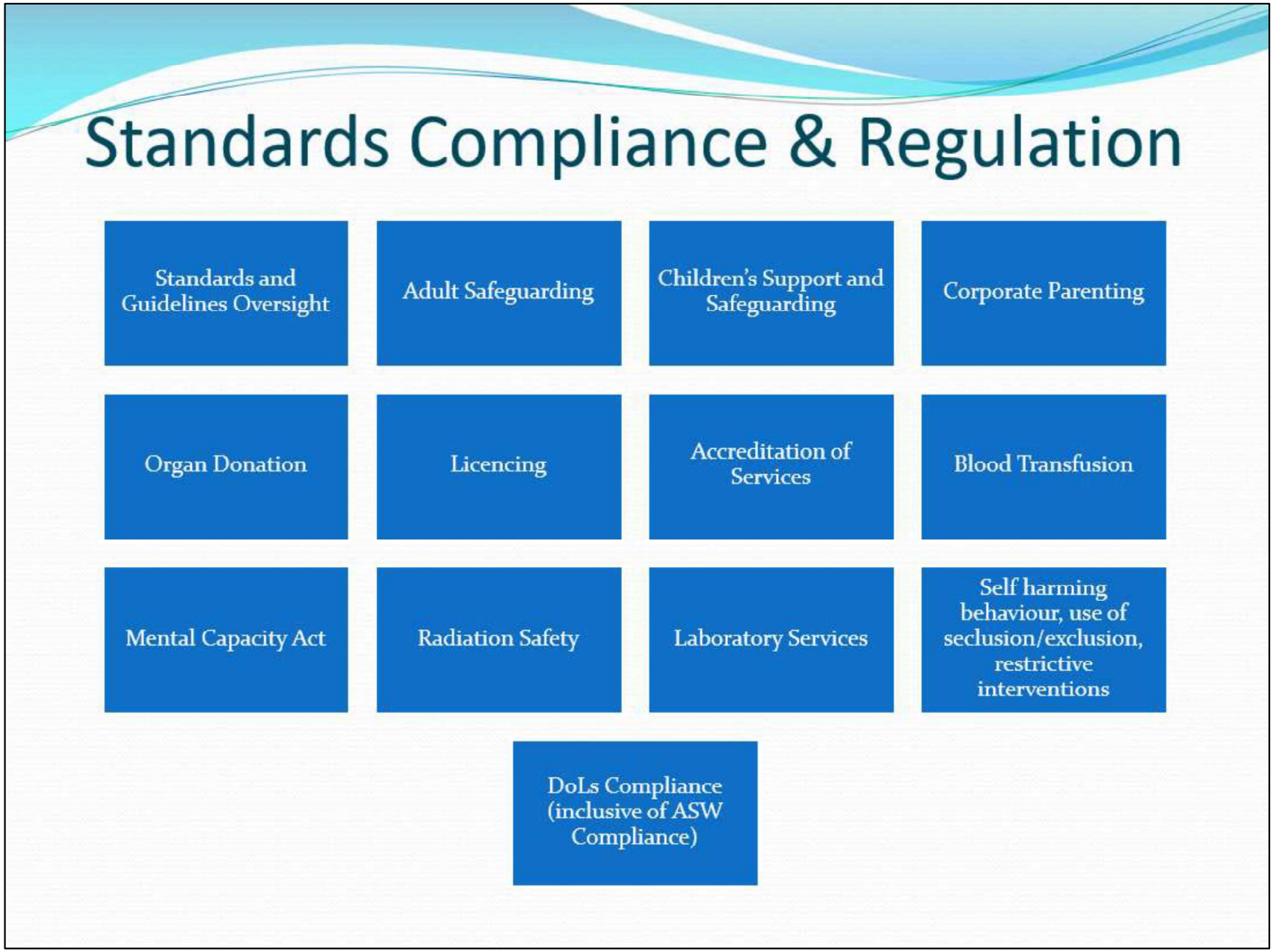
IMPROVEMENTS UNDERWAY – SERVICE USER FEEDBACK
Development of Service User Feedback Awareness training package – Corporate Mandatory Training for all staff across the organisation, aiming to go live by 1st April 2024
Service User Feedback Pilot in relation to early resolution – to commence April 2024
Implementation of a procedure for the management of Independent Clinical Record Review of Complaint. Information on how complaints relating to professional members of staff are managed across the Trust along with the opinions, thoughts and views on the process of an Independent Review have been obtained. Staffing resources within the Corporate Service User Feedback team has prevented progression of this work. It is planned this will be revisited in April 2024
IMPROVEMENTS UNDERWAY – PATIENT SAFETY DATA & IMPROVEMENT
SHSCT Safety Framework – Drafted and presented to SLT on 20.02.24
IMPROVEMENTS STILL TO BE ACHIEVED – INCIDENT MANAGEMENT
Increased use of 'Hot Debrief' for Level 1 SAI reviews across the Trust to ensure Learning is rapidly identified and shared
Audit evidence provided to support SAI recommendations which have been fully implemented
SAI Theming
Audit compliance with Corporate SAI Policy and Procedure
Inclusion of SAI recommendations in the triangulation of Governance activity information
Development of a Professional Governance Information System (PGIS) to further improve oversight and assurance of governance activity in relation to staff
IMPROVEMENTS STILL TO BE ACHIEVED – DATIX INCIDENT MANAGEMENT SYSTEM
Focus on Unapproved Datix incidents and reporting of these in the Weekly Governance Meeting, Governance Committee and at Governance Coordinators meeting
Development of Datix Training package for reviewers
Development of Datix Workshops for staff to access to learn or refresh on Datix functionality

Development of Risk Register module on Datix
Explore the interfaces between Datix and Northern Ireland Digital Identity Service (NIDIS) and Encompass
Development of standardised datasets for reporting of Complaints from Datix
IMPROVEMENTS STILL TO BE ACHIEVED – SERVICE USER FEEDBACK
Implementation of NIPSO Model Complaints Handling Procedure
Development and implementation of Complaints Reviewer training package
Develop a pathway for Liaison Service involvement in Complaints
IMPROVEMENTS STILL TO BE ACHIEVED – LIAISON SERVICE
Development of Liaison Service to support staff impacted by SAIs and Complex Complaints, either directly, as a manager or member of the review team
IMPROVEMENTS STILL TO BE ACHIEVED – RISK & LEARNING
Provide support to operational directorates to ensure that each directorate level risk register is dynamically populated and consistent with corporate requirements
Support the implementation of the Datix system upgrade and adaptation of modules regarding the management of risk
Coordinate the Trustwide Risk and Clinical Governance Training programmes for all relevant staff including developing a training matrix for Clinical and Social Care Governance activities
Support the creation and provision of an education and learning programme which integrates learning between SAI's/M&M/Litigation/Datix Trust-wide
IMPROVEMENTS STILL TO BE ACHIEVED – PATIENT SAFETY DATA & IMPROVEMENT
Further develop the support to Patient Safety meetings to maximise feedback and learning

Received from SHSCT on 05/03/2024. Annotated by the Urology Services Inquiry.



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A. And, again, their reach into all of this. And, again, that has been I think really important in supporting families or carers who find themselves, you know, part of an SAI process, and giving their feedback into the system, and supporting them, and helping form the Terms of Reference in relation to the SAIs. 14:53

184 Q. Can I pick up on reporting?

A. Yes.

185 Q. It's the first one in front of us and improvements to date are listed there. I understand, and we've talked about this perhaps in passing, that as part of the enhanced reporting arrangements, there is a weekly governance debrief meeting? 14:54

A. Yes.

186 Q. And I think as we maybe touched on this morning, that is the - that meeting is facilitated, if you like, by a weekly governance report? 14:54

A. Yes.

187 Q. We can take a brief look at that. TRU-306247. Sorry, that's wrong reference. TRU-305113. And this is under Dr. Austin's leadership? 14:55

A. Yes.

188 Q. Help us in the context of improving the governance processes to understand what this is doing in context. So you have this weekly debrief. This is a detailed report. I think the first page perhaps helpfully summarises it's significant content. So it's giving an up to the minute outline of various developments that flow from some governance tools. So here are your up 14:55

to the minute SAI situations, notifications and reports. Scrolling down. Early alerts, catastrophic incidents, and it goes on into litigation, national clinical audit, information governance, and then descriptions of various activities, including SAIs in each directorate, Trust wide governance issues such as litigation, Coroner's cases. So what is the purpose of introducing such a regular and, indeed, very heavily detailed arrangement into the system? 14:56

A. So this is the business of clinical and social care governance, and the aspiration behind this was to bring it all together in one document on a weekly basis to inform not just the Medical Director's office but the other Executive Directors in relation to the quality and safety of the system, you know, so that they can then use that to, you know, challenge the system in relation to improvement. But also then to report this to the Senior Leadership Team on a weekly basis, and I think - I mean it is a detailed document. The way we deal with it every week is that Dr. Austin takes us down through this, highlights the areas he is concerned about, and then there is challenge on that in relation to, you know, questions being asked to directors in terms of some of the immediate episodes, but also then any patterns in relation to this. So it's used in that way. But then it also underpins, in terms of the quality and safety meeting that goes to, that, you know, it goes to governance, and also whenever we're undertaking our risk and assurance meeting through SLT, 14:57 14:57 14:57 14:58

it helps inform that as well because, you know, it's very powerful actually having patient stories like this in a senior management leadership team meeting every week, and this is the easiest way we can get to it. Now these all tend to be the things that have gone wrong. 14:58

I think the next part in relation to this is how we - and this is the conversations we've been having with the governance team is, how do we now take this into a more robust process for learning? So, you know, when I look down through that I can see patterns arising in relation to, for example, insulin, or anticoagulants, or violence and aggression. So what are we doing in a concerted way to actually deal with those areas, and how do we report on the improvements in relation to that? So that's what they're working on now. 14:58 14:59

189 Q. So this gives up-to-date accessibility and understanding for the corporate team?

A. Yes. 14:59

190 Q. About what's going on in the services one-by-one.

A. Yep.

191 Q. And we can see it in the paper that each service is, or directorate, more appropriately, is represented. Contrast that with where you came from. Would this kind of detail have made its way to the corporate level? 14:59

A. No.

192 Q. Or would it have been - "lost" is the wrong word, but

- ***Cancer Services received a monthly report to monitor tracking position.***
- ***If cancer trackers identify any delays with patients on cancer pathways, they follow up on these issues with consultant secretaries and consultants as required. Cancer MDM chair may also be alerted to significant delays or issues. Cancer Senior management team and specialty Heads of Service / Assistant Directors will also be alerted to any significant issues***

5.57 Dr. O'Kane put the following flesh on the bones of the above summary during her evidence to the Inquiry on Day 90[316]:

"We put additional funding against the MDM in relation to not just the job planning process but also increasing the number of CNSs who take part in all of that, making sure that there is medical presence there, and also then we invested in trackers, so that when a patient comes through this process now the tracker picks them up and makes sure that there is no gaps in terms of, you know, the outcome of the MDM being followed through…

…That is then audited on a regular basis, and they will take - out of samples of 38 they will take 5 cases and make sure, based on that sample size, which is, you know, in and around 12%, they'll do that on a regular basis to make sure that there aren't any patients falling through the gaps. Right."

5.58 Dr. O'Kane in her evidence[317] in relation to Recommendation 1[318] – *the SHSCT must provide high quality Urological Cancer Care for all patients* - also explained the following:

"Q…And then a third stage, or a third portion of the work, there was data mapping for

[316] TRA-11742
[317] Also on Day 90 at TRA- 11751
[318] TRU-306490

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

each patient pathway or each condition pathway. One can see that that has a yellow rating. Some of the work in urology and I think in renal services isn't yet complete. We can see in the middle paragraph:

"The immediate work needed to be delivered in relation to Urology has been completed but the Trust is adopting an ongoing improvement focus across all cancer pathways supported by the cancer service improvement league."

So the RAG status for this sub-action is therefore yellow, it's ongoing work.
A. Mm-hmm.
Q. Are you satisfied or are you in a position to be satisfied or assured that this aspect of the recommendation is in a good place, has been appropriately conducted and applied?
A. I think I would have liked it closed out, but I know that they are working on the aspects of this. To try - for the parts of this that haven't been delivered on yet, this will now - I mentioned yesterday about the External Reference Group and about how we're now moving the programme for improvement within the Trust completely, so that will be overseen by the Director of Transformation and Improvement in terms of ensuring and, you know, holding to account essentially the directorate in relation to making sure that these are delivered on over the next few months. So, I mean, we would all like it to be green, but I am confident that, you know, as this works gets underway that we will have this done."

5.59 Dr. O'Kane explained, when questioned in her evidence[319] in relation to Recommendation 2[320] - *All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care – this should meet the standards set out in Regional and National Guidance and meet the expectations of Cancer Peer Review* – which was the only recommendation to have an amber RAG, the following:

[319] Also on Day 90 at TRA- 11763
[320] TRU-306493

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

"Q. ….It concerns the allocation of a key worker and the Trust is not currently in a position to stand over in every case that those allocations are taking place. It records here:

"As the new CaaPS functionality is not yet available which will allow monitoring of this and other KPIs, and given that sample audits have been undertaken for Urology, we have a level of assurance on this. However, we cannot fully sign the recommendation off as being green."

So there's that frailty in the system whereby you don't currently have a methodology to stand over appointments of key workers and compliance with their key performance indicators in every case, is that right?
A. We have - we do it manually, you know, in terms of trying to keep a running score to make sure that the patients are aligned and there's a monthly feedback in relation to that. But in terms of it being recorded on the system robustly and signed off by the CNSs, they're not able to do that. And CaaPS is one of a number of pieces of software, you know, that functions across the NHS at the minute that is awaiting the implementation of Encompass. That rollout of Encompass regionally started with the Southeastern Trust in November last year. The Southern Trust will get to this in April 2025. So this is going to take at least another year/18 months."

5.60 In her evidence[321] on Day 91, Dr. O'Kane also provided the following additional information in relation to the Key Worker issue:

"MR. WOLFE: Good morning. Good morning, Dr. O'Kane. Just going back to something I was asking you about yesterday. We were looking at the outworking of the recommendations following the Serious Adverse Incidents Reviews, and we were looking at the audits that were and have been carried out in respect of, for example, quoracy, in respect of cross-referencing from pathology, and then we came to nursing and we identified something of a gremlin in the works in the sense that CaaPS requires

[321] TRA- 11818

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

further work so that we can have an electronic record of the allocation of key workers to patients, and I was raising that with you as a concern because it's essentially a concern within the recommendation report that you have helpfully brought to our attention. You did say that there is nevertheless a paper check or a manual check that key workers are being allocated, and I just wanted, after that long introduction, to bring you and bring the Panel to some references for that.

If we go to TRU-304474. And we can see this dates back to November 2022. And Kate O'Neill, one of the nurse specialists, is writing to Wendy Clayton in response to a request for data outcomes, or audit outcomes I should say, and she sets out some information which helps to clarify that in the vast majority of cases key workers had been allocated, and gives explanations for the cases where allocation had not yet taken place. Any further comment you'd like to make on that?
A. I have seen more up-to-date information in the weeks that suggests that that has moved on but is still being, the information is still being collected in the same way, so we can provide the Inquiry with that."[322]

5.61 In relation to the actioning of MDM outcomes, Dr. O'Kane explained[323]:

"Q. MR. HANBURY: Just another thing on the audits of the multi-disciplinary team working after Dr. Hughes's review of the nine SAIs - you've already answered one of them. In Recommendation 5, about the extended tracking, which you remember, the problem for a few patients, especially with prostate cancer, is that they were started on hormones and subsequently not referred for radiotherapy. Are you confident that that has been picked up with the new system of extended tracking?
A. Yes. And certainly in terms of the audits that are being done, you know the 5 out of 38 every week in relation to the patients described, it would suggest that they are being done. And that - again the trackers were specifically employed to undertake that function and to make sure all aspects of the treatment was actually happening, yes."

[322] Please see TRU-409752 – TRU-409752
[323] Also in her evidence to the Inquiry on Day 91 at TRA- 11895

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

5.62 And in respect of the prescribing of Bicalutamide 50 mg and the prevention thereof, Dr. O'Kane had the following to say[324]:

> *"Q. MR. HANBURY: So what's to prevent that happening now? What's to prevent that happening now?*
> *A. Well, all of those prescriptions should originate within the Urology Department. So they have a good programme in terms of, I think, being aware of all of this and making sure that everybody - I mean this is talked about a lot in terms of being compliant with all of this. Right. Our pharmacy processes at this point in time aren't robust enough to pick up, you know, if it's still being prescribed for the wrong reason, in terms of whether it's 150 or 50 milligrams of Bicalutamide. But certainly pharmacy is very aware of this and, you know, will appropriately challenge if they're concerned. But I think the ultimate solution to this will again be the implementation of Encompass next year. Now, I appreciate that's a year away. Because the Northern Ireland version of Encompass should bring together the different aspects of the clinical pathway, and the artificial intelligence that's built into the Encompass programme should try totally the prescription of Bicalutamide to the diagnosis and should be able to pick up that actually this is outwith what it should be in terms of, you know, the cancer disease process and metastasis. So that artificial intelligence that kind of guides the system and it should be helpful with that."*

5.63 In relation to picking up the use of medicines contrary to Guidelines and outside of licence, Mr. Haynes explained in his evidence[325], when questioned by Dr. Swart, that the starting point for such a patient would be a recommendation from MDT for specific treatment and that the concern about Bicalutamide was the patient not receiving the appropriate prostate cancer treatment. Mr. Haynes explained that the audit process of the MDT outcomes would highlight the patient who has not had the recommended treatment which would in turn bring the patient back both to the consultant and to the MDT allowing for peer challenge. Mr Haynes further indicated that he would expect the MDT chair to bring that

[324] Also on Day 91 at TRA-11899
[325] Day 88 at TRA- 11520

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patient to the medical line management – escalating the issue. Mr. Haynes also referred to support in terms of contact directly through the Deputy Medical Directors and the Medical Director and to those relationships and the regularity of meetings being such, that the issue would be able to be raised.

5.64 In respect of clinical audit, Dr. O'Kane explained in her evidence on Day 89[326] that, at a point in time in the past in order to save money, the clinical audit team had been stood down and that now as part of the whole governance review it had been reinstated. On the same issue, asked whether there had been any identifiable change in respect of clinical audit in recent times, Mr Haynes described to the Inquiry how there had been a 'huge change' for the better[327].

5.65 Dr. O'Kane also gave evidence on Day 89 in relation to the Champion report[328], indicating that it gave her a framework in terms of improvement in relation to the overall corporate governance of the organisation and had been helpful in developing the operational governance within the Trust and that:

> *"…we have concentrated on completely reforming the way we undertake corporate governance and, again, that has taken a lot of engagement, reflection, discussion, and we now have a revised corporate governance structure in place that brings patient safety and the quality of care very much into the minds of staff within the organisation, and feeds into the Governance Committee and sits alongside the Risk and Assurance Committee - or, sorry, the Risk Assurance and Audit Committee - that basically then quality assures some of that work that comes in. And then the other committees that are developed, the other five committees that are alongside that then are to support the overall approach to corporate governance."*

5.66 Mr. Haynes commented on the actions taken as a result of the Task and Finish Group (taking forward the Hughes SAI recommendations) and assurance

[326] TRA- 11617
[327] TRA-11487 line 22 to TRa-11488 line 24.
[328] TRA- 11609

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

processes surrounding the MDM in his evidence on Day 88[329] when asked about a number of new support staff being brought into the MDT arena indicating that the roles are very much part of the assurance processes that surround the MDT, that the Cancer Information and Audit Officer was the individual who does a monthly audit of the outcomes recommended from MDT addressing the question are they being actioned and that he gets a report from that individual. Their role, according to Mr. Haynes, is the assurance process around MDT.

5.67 Mr. Haynes also gave evidence on Day 88[330] addressing culture change in results sign-off. Mr. Haynes referred to the first step of the monitoring process being undertaken by himself and Wendy Clayton and to all of the consultants and nurse specialists within Urology using electronic sign-off for their results management. Mr Haynes referred to a red/amber/green table for each consultant's reporting and indicated that it tells him how long a result has been outstanding and awaiting action. Mr. Haynes referred to an escalation process indicating to the consultant that they have fallen into amber and a formal meeting to establish a way back to green if a consultant had fallen into red. Mr. Haynes suggested that the mere availability of an overview had helped to change the culture and that "*we all know how each other is doing, and no one wants to be bottom of the table. You don't want to be bottom of the class so it generates a culture whereby everyone keeps on top of things. If you get an e-mail that shows you as an outlier, it changes the way you behave*".

5.68 Mr. Haynes gave evidence[331] in relation to Key Worker allocation and in relation to reports directed to the role of the Key Worker indicating that :

> "*A. Yes, to the best of my knowledge that is all implemented. I think there is an aspect to it that was required for the monitoring, for ease of monitoring, that required some regional input on the CAPP system, the cancer -- the computer system that's used for*

[329] At TRA- 11461. Further comment is at TRA-11463 to TRA-11465.
[330] TRA-11466
[331] Also on Day 88 at TRA- 11474

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recording the cancer patients. The actual, the physically doing it and auditing it and recording it is all being done."

5.69 In respect of the actioning of MDM outcomes, Mr. Haynes gave the following evidence[332]:

" A. So the audit is done on a monthly basis. Where there are, if you like, discrepancies, where there's an outcome or a query regarding the outcome, it is raised first-off with the clinician themselves. As I mentioned earlier, there may be a simple oversight or failure of the requesting process that means something hasn't been requested, or it may be that the clinician has forgotten to bring the patient back to MDT when they've changed it, so it allows for the clinician to actually look at it and bring it back if required. But if there's no action, then my understanding is that that is then escalated to the MDT Chair to bring it back to the MDT...

…A. So the commonest situation we've had - and from memory it has not been this process that brought the patient back to MDT, it has been the clinician who has brought the patient back to MDT - has been where the patient's wishes are different to those that have been put or recommended by the MDT. Where you have that consultation taking place with the clinician and the Clinical Nurse Specialist, and you have in that well-counselled patient they are making an effective decision to go with a different plan, it is very difficult to change a patient's decision when they've made a reasoned judgement themselves. We haven't had to challenge a clinician, saying I think we should do something different."

5.70 Mr. Glackin gave evidence on Day 63[333] addressing the actioning of MDM outcomes, indicating that there is now in place a random audit of whether or not outcomes have been adhered to and that information is brought back to the MDT and shared with the MDT. Mr. Glackin indicated that he also receives that report as the lead clinician, and that if there are cases that don't appear to match what the

[332] Also on Day 88 at TRA-11476.
[333] TRA- 08243

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outcome was, then those cases are addressed on an individual basis. Mr. Glackin's evidence on Day 67[334] addressing the audit of MDT outcomes included the following:

> *"A. So following the appointment of Mark Quinn, and under the direction of Angela Muldrew, we have a monthly audit process of outcomes from MDT to ensure that the outcomes are followed up and actioned. That report is provided to me, and it's also provided to the whole of the MDT, so that if there are any shortcomings or points that have not yet been actioned, they can be brought back to the meeting and discussed and actioned. So, that's been in place for almost a year. So that is working. We have a report from the Pathology Department that's run I think on a weekly basis to ensure that all pathology is brought to the meeting that should be. So they're at least two of the reports that are being supported by cancer services."*

5.71 Kate O'Neill's evidence[335] in relation to Key Worker allocation referred to a proforma[336] allowing for improved auditing of Key Worker activity and explained that the Key Worker is named and that the system operates by way of a minimum data set and is audited.

5.72 Kate O'Neill also gave evidence[337] addressing other improvements and Key Worker allocation including how increased resources *'have transformed [her] working life'*. When asked about the potential for the issues around Key Worker allocation in the 9 SAIs to arise again, she offered the following evidence:

> *"A. I think we have eliminated that significantly. There is still improvements that I feel could be done and we'll work towards those. One of those would be more engagement with the ward-based patients, whether it could be considered or not going forward if we had sufficient resources to actually have a CNS on the ward round. You know, that provides a format for engagement with the ward staff and patients."*

[334] TRA-08725
[335] Day 42 at TRA-12059
[336] At WIT-81164.
[337] Day 42 at TRA- 12106

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

5.73 Leanne McCourt gave evidence[338] comparing the current system in relation to Key Worker allocation as compared to that at the time of the SAIs in the following terms:

" A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that."

5.74 Also in her evidence on Day 43, Leanne McCourt discussed the system now and whole of pathway tracking as an idea for improvement[339]:

"Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.
Q. And do you think that would be a good idea?
A. Absolutely."

5.75 The progress made is perhaps best summed up by Mr. Haynes when he gave evidence on Day 88, when he said[340]:

[338] Day 43 at TRA-05479
[339] TRA-05487
[340] TRA-11478

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

"Q….Overall, taking into account your experience of working within this MDT before 2020 and knowing the environment now in light of these changes, how would you characterise the improvements? Has there been meaningful progress and is it a safer environment for your patients?

A. I think there has been significant progress. It's a safer environment for patients. It's also an environment where we as clinicians feel safe. We know that there are processes to make sure that everything is happening as it should be."

Conclusion

5.76 The issues in respect of Mr O'Brien's practice and that of the Trust which came to a head in 2020, and which were subject to SAI review led on to further patient scrutiny by the Trust in the Look Back Review and the SCRR process.

5.77 The Trust accepts that the cancer care received was not that which would have been expected.

5.78 Nonetheless, it is hoped that the Inquiry, patients and their families, and the public will be assured now by the steps taken by the Trust in relation to the issues identified to improve processes surrounding cancer care and the Urological Cancer MDT so that the risk of similar issues arising now or in the future has been significantly reduced.

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6.32 Many of the improvements initiated by the Trust in respect of the above issues have already been referenced in these submissions (and/or will be summarised in Chapter 7). For example:

a. In respect of results, the substantial improvements in this sphere have been addressed in chapters 4 and 5 and include the e-sign off facility, better training and guidance to secretarial staff, and the monthly information dashboard (including information regarding their triage, dictation, and results) available to all consultants[367].

b. In respect of medical management, significant improvements on this front have been described in the written and oral evidence of Maria O'Kane and Mark Haynes[368]. Maria O'Kane summarised the remodelling of medical management as follows: '*So, on the back of this report in 2020, what we did was revised - the job descriptions as Clinical Director and Associate Medical Director did not lend themselves to supporting the medical leadership that was needed. So we, you know, we undertook a complete revision of all of that, strengthened those roles, introduced an increased number of Clinical Directors and Divisional Medical Directors instead of Associate Medical Directors, increased - introduced Deputy Medical Directors and strengthened that function. All of the people who were selected were put through a fairly rigorous interview process and then have been given some support and training around that*'.[369] In short, the improvements include both better training given to, as well as greater numbers of, medical managers.

c. In the area of drugs Tracey Boyce[370] in her evidence to the Inquiry explained the pitfalls that exist with a paper based prescribing system and the positive changes which will be brought about with the introduction of Encompass: "*Today, we still have a paper-based system until Encompass starts in the South Eastern*

[367] See also Mark Haynes Transcript TRA- 11465 – 11468, Day 88, Page 95-98 and TRU-320269-Administrative and Clerical Standard Operating Procedure, Mark Haynes
[368] See also the Medical Leadership Review March 2020 at WIT-79127.
[369] TRA- 11689, Day 90, Page 17
[370] TRA- 05908, Day 46, Page 83

Received from SHSCT on 31/05/2024. Annotated by the Urology Services Inquiry.

Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening."[371]

d. And in terms of visibility of issues such as Mr O'Brien's continued use of monopolar resection, we have already touched in previous chapters upon significant improvements in the area of clinical audit. Mark Haynes summarised those improvements as follows: *"It's a huge change. So we have a member of staff from the audit team assigned to urology for audit purposes. She attends our Patient Safety meetings with us. She's constantly in communication with us with regard to the ongoing audit projects and, indeed, just yesterday was in contact with me about -- I think it's one of them on there or it's one that's on the current one. It's one of the ones through BAUS. It is there. It's the top one. So it's a much greater engagement and it's led to a massive improvement through the audit programme that we undertake in the team. As you say, what we have there is multiple levels of priority in terms of the department for audit, and they go down from "external must dos", down to "for interest", if you like, audit. The findings are presented at our Patient Safety meeting by our trainees. They have presented at our regional audit meeting for urology as well, and I know the trainees are looking at -- where appropriate, they're looking to put their projects in for presentation at national meetings as well."*[372]

e. And finally for present purposes, in respect of pre-operative assessment, Mr Haynes[373] described in his evidence how different the approach to pre-operative assessment is now: "*The preoperative assessment team are engaged and*

[371] TRA- 05909, Day 46, Page 84
[372] TRA- 11488, Day 88 Page 118
[373] TRA- 11484, Day 88, page 114

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clinically led to try to improve that position. As I've said, within our service our theatre scheduling is done by our scheduler, so where patients haven't been through preoperative assessment, they are not added, or an active decision needs to be made and is made in communication between an anaesthetic team and a surgical team as to whether it is reasonable to proceed without it. Invariably the answer to that is no."

6.33 Thus, the panel can take comfort from the improvements implemented already by the Trust in this regard that the deeply unfortunate issues that arose with Patients 90 and 91 are unlikely to occur today.

Conclusion

6.34 As indicated above, the Trust accepts that it failed to take a sufficiently robust approach to managing Mr O'Brien's resistance to change / idiosyncratic practice across a number of areas and across a wide span of time. His unusual intransigence was undoubtedly a significant contributory factor in all of this and a feature that may well have posed significant challenges for any healthcare trust. Nonetheless, his unilateral, *'I know best'* approach to aspects of his practice was permitted to continue for too long.

6.35 The Trust also recognises that some of the above failings may have exposed patients to the risk of harm, for which it apologises.

6.36 However, the Trust believes that the Inquiry and the public can be assured by the remedial measures it has subsequently taken that recurrence, now or in the future, of the issues that arose in the above areas is unlikely.

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f. GIRFT;

g. Trust Board Reform.

(a) The Champion Review

7.5 Some of the backdrop to why the June Champion Review was considered necessary during 2019 can be found in the evidence[374] of Shane Devlin, Trust Chief Executive from 2018 to 2022. In short, he had concerns that the 'spend' on governance seemed light, that he had a concern about the absence of regular flow of Clinical and Social Care Governance ('CSCG') information to the SMT, and he was concerned regarding the level of data on quality and safety coming to SMT. Similar evidence was given to the Inquiry by Maria O'Kane, who was Medical Director at the relevant time and who, together with Mr Devlin saw the need for clinical and social care governance reform within the Trust[375].

7.6 The November 2019 June Champion 'Clinical and Social Care Governance Review'[376]made 48 recommendations (which are at WIT-47007 to 47012) covering everything from Board Governance to 'being open' to management of adverse incidents and SAIs to clinical audit to morbidity and mortality.

7.7 Since the publication of the report, the progress of the Trust implementation of Ms Champion's recommendations can be charted by reference to a Trust spreadsheet which is updated as the recommendations are implemented. The version applicable when Dr O'Kane gave evidence in March 2024 can be found at TRU-306233 to 306243 and was up to date as at 05 March 2024. Of the 48 total recommendations, 34 had been completed and 14 were in progress.

7.8 Maria O'Kane put flesh on the bones of the report and the implementation spreadsheet by explaining in her oral evidence[377] the impact of the Review and the

[374] WIT-00036 bottom third of page to WIT-00038
[375] TRA-11605 -11606
[376] WIT-46954 to WIT-47012
[377] TRA-11676 and TRA-11772

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changes brought about under it, she explained some of the progress of its implementation and what it has led to including her Corporate Governance and CSCG Governance Functions and Structures Proposal[378] as well as the restructuring of the Acute Directorate into two smaller, more manageable directorates[379].

(b) Chief Executives' Evidence

7.9 Not only have the current Chief Executive and her predecessor been able to provide evidence about the backdrop to, and drivers for, initiatives like the Champion Review, they have been able to provide the Inquiry with other useful evidence regarding improvements in governance and other areas.

7.10 For example, Shane Devlin's evidence also provides details of reforms he initiated in respect of the senior management team structure[380].

7.11 In a much broader sweep, Maria O'Kane has in her evidence been able to provide considerable detail of improvement and reform work undertaken during her tenure as both Chief Executive and Medical Director – i.e., from 2019 onwards. For example:

a. In her statement no. 29 of 2022 (from WIT-44934) she summarises multiple governance improvements introduced during her tenure. For example:

i. From WIT-44973 to WIT-44977 (para 7.9) she details governance improvements in multiple areas including adverse incidents, SAIs, clinical audit, patient safety, complaints, medical oversight of litigation, M&M, learning from experience, whistleblowing, 'being open' culture, MHPS, medical appraisal, revalidation, job planning, private practice,

[378] WIT-47270
[379] TRA- 11772 to TRA-11778
[380] WIT-00031-00033 at question 7

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medical education, infection prevention and control, R&D, emergency planning, and business continuity.

ii. From WIT-445014 to WIT45027 (para 21) she provides details of some of the above improvements under the headings of medical professional governance improvements, clinical and social care governance improvements, and strengthening of medical leadership (including, in particular, in Urology).

iii. Some further detail on the above changes is contained in the tables at para 36 (WIT-45041) and para 37 (WIT-45043) and, in more detail, in para 51 (WIT-45082) and the attachments referenced there. An overview is then provided at para 71.16 (WIT-45184 to WIT-45186).

b. In her statement no. 3 of 2022 (from WIT-11149) she summarises improvements undertaken in response to the 2018 MHPS Determination and the Mr O'Brien SAI Reviews (at WIT-11161 to WIT-11172).

c. In her oral evidence to the Inquiry in March 2024 (TRA-11525 to TRA-11944) and through more recent disclosure to the Inquiry (such as that running from TRU-305017 to 306518) she has been able to bring the Inquiry up to date in respect of the reforms outlined in the above witness statements.

(c) Dr Hughes' SAI Reports

7.12 The 9 SAI Review Reports and Over-arching Report were produced in the Spring of 2021 and can be found at DOH-00001 to DOH-00135.

7.13 A 'Task and Finish Group' was created to oversee the implementation of their recommendations, Terms of Reference for which are at WIT-11509 to 11510.

7.14 Mark Haynes addresses the 2020 SAIs in his oral evidence on Day 88.[381]

[381] TRA- 11456- Transcript 22 February 2024 p86 line 107- p108 line 132 and at TRA- 11522 p152 line 4- line 22.

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7.15 Maria O'Kane also addressed the progress of implementation of the recommendations in her evidence from TRA-11737 to 11754 and 11763 to 11766.

7.16 The BSO audit (TRU-305875 to 305886) of implementation of the recommendations has also been made available to the Inquiry and was considered in evidence at TRA-11748. It showed 65% implementation by November 2023.

7.17 A more up to date picture of the state of implementation (as of 8 March 2024) can be found in a tabular document at TRU-306489 to TRU-306514 and was addressed by Dr O'Kane in her evidence, the 68 SAI recommendations were 'streamlined' into 11 major recommendations with 'subtitles' beneath them. A simple overview of the table reveals that the overwhelming majority of the recommendations have been shaded green, meaning that they have been implemented.

(d) The Royal College of Surgeons Invited Review

7.18 This has been described in the previous chapter. In summary, within their report the Review Team identified 17 recommendations which fell into two categories, urgent recommendations to address patient safety risks, and recommendations for service improvement.

7.19 These recommendations were the subject of an implementation action plan within the Trust. The iteration of the action plan considered in evidence is dated 9th October 2023 and can be found at TRU-304948 to 304965. As with other such plans it use a 'RAG' rating and, of the recommendations in October 2023, 4 were red, 9 were amber, and 4 were green. Implemented steps include developments such as the implementation of a new consent police (recorded at TRU-304951). Of the recommendations where implementation had not commenced by late 2023, some of these related to issues beyond the control of the Trust. For example, recommendation 12 - '*The Trust must ensure recognition amongst management and*

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clinicians that no patient should wait for longer than a pre-agreed period for surgery and follow up'[382]. Commissioning and resource restraints evidently hinder the Trust's capacity to act on same. Recommendations 4 and 14, marked 'red', relate to recommendations for audits which capacity is awaited. It is submitted that, of the recommendations which have been completed or are in progress, the action plan contains a detailed timeline of steps taken to address the recommendations[383], and it shows that significant improvements have been made.

7.20 In terms of oral evidence on the issue, Maria O'Kane gave evidence back on Day 15[384] about the backdrop to inviting the RCS in to carry out the review and she was taken to a number of the above documents regarding implementation of their recommendations in her evidence on Day 90 from TRA-11766 onwards.

(e) RQIA

7.21 The RQIA produced a review report in respect of the Trust's SCRR process in September 2022 [385]. It contained 18 recommendations which can be found from TRU-157770- TRU- 157773. Briege Donaghy of RQIA gave evidence on Day 86 of how these recommendations were accepted by the Trust[386].

7.22 Evidence of the progression of implementation of these 18 recommendations (which were broken down into 25 separate required actions[387]) can be found in a number of places including, for example:

(a) TRU-181971- TRU-181981- This 11-page tabular document (in the familiar RAG-rated format) shows the state of play in respect of implementation in

[382] TRU-304960
[383] TRU-304959- By way of example recommendation 11 which is now marked 'green' required the Trust to review waiting list processes, the specific steps taken to implement this recommendation are date stamped and include recruitment of a Scheduler, confirmation audits will be undertaken relating to private patients moving to the public sector and waiting list processes/prioritisation of patients, and exploration of pooled waiting lists ,
[384] TRA-01572 Day 15, p161, line 19 to p162 line 15 and TRA- 01576 p165 line 19 to p166 line 3
[385] TRU 157737-TRU157782
[386] TRA-11217 Day 86, p56, lines 7-13.
[387] i.e., some recommendations distilled to more than one action.

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November 2022, very shortly after the RQIA report was issued. At that stage, 9 actions were rated green, 13 were amber, and 3 were red.

(b) TRU-183363–TRU183377- This (now 15-page) version of the same document shows the state of play by April 2023, approximately 6-7 months post-publication of the report. By that stage, 22 actions were rated green, 2 were amber, and 1 was red. This remains the position and is related to the fact that the lookback has not yet concluded.

(f) Getting it Right First Time ('GIRFT')

7.23 The October 2023 *'Getting It Right First Time - Urology across Northern Ireland'* Report can be found at TRU-320188, and its general recommendations at TRU-320193 to 320195 and its Southern Trust specific recommendations at TRU-320218 to 320220.

7.24 The GIRFT report is enlightening because it gives the Inquiry some potential insight into how the Trust's Urology Service compares with others in Northern Ireland. As we have done in the other chapters, we highlight this as a potential important point of context. Of potential note in this regard are a number of features including:

a. The recruitment issues that are apparent in the Trust compared to its comparators – see the table at TRU-320200;

b. The impressive array of services performed by CNSs in the Trust compared to other NI Trusts – see the table at TRU-320201;

c. The waiting time averages across the Trusts – see the table at TRU-320202;

d. The breadth of stone services the Trust offers – see the table at TRU-320213.

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7.25 In the family of reports and reviews yielding up recommendations to the Trust, GIRFT is a mere youth, having reported only in October 2023. Nonetheless, the Trust have been actively implementing the recommendations and, even at November 2023, it is clear that substantial progress had been made with 33% of recommendations 'in the green' – see in this regard the TRU-320313 to TRU-320331.

7.26 By 6 March 2024 the updated Action Plan updated (at TRU-306468) 39% of the recommendations had been implemented.

7.27 The impact of the GIRFT report was described in detailed terms by Mark Haynes in his evidence on Day 88[388]. He described how it was 'broadly welcomed'[389] that 'it supported the direction of travel we wanted to go'[390] and that GIRFT is led by clinicians and supported by the urology team in the Trust[391] Again, by way of potentially important context, and as fairly noted by Mr Wolfe KC in his questioning of Mr Haynes, the GIRFT report recognises the decade long deterioration of urology services in NI and how it is underrepresented in terms of urologists per head of population[392] .

(g) Trust Board Reform

7.28 Eileen Mullan, who has been a non-executive director on the Trust Board from 2016 and Board Chair since December 2020 has provided quite a bit of written and oral evidence charting improvements at the level of the Trust Board and its committees. This can be found in her witness statement from WIT-100434 to WIT-100568 and in the transcript of her evidence on Days 77 and 78 from TRA-09938 to TRA-10190.

[388] TRA-11493 Transcript page 123, TRA-11496 p 126, TRA-11500 p130 line 17 – p137 line 5
[389] TRA-11501 Transcript p131 line 12
[390] TRA-11504 Transcript p134 lines 23-24
[391] TRA-11505 Transcript p135 lines 11-14
[392] TRA-11505 Transcript p135 line 28 to p136 line 20

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7.29 A non-exhaustive list of examples of improvements and reforms covered by Ms Mullan in her detailed witness statement include the following:

a. Ms Mullan, who was still a NED when the Champion Review was commissioned has provided evidence on the outworkings of the Review at WIT-100462 to 100464.

b. On the issue culture, she has described initiatives taken by her to encourage an 'open, honest and psychologically safe environment' (WIT-100466 at para 15.7).

c. She has described improvements in reporting from committees to Trust Board which she has initiated (WIT-100475 para 18.8) and in developing a Trust Risk Appetite Statement (WIT-100479 para 21.5).

7.30 In her oral evidence on Day 77, Ms Mullan provided multiple examples of improvement at Board level. Some examples include the following:

a. She was asked to look at the Terms of Reference of the Governance Committee and what she then knew about the evidence, and she indicated that the Governance Committee was not provided with the information in light of what we know now, through the Inquiry[393] .She went on to indicate that the Governance Committee's Terms of Reference would now be satisfied by the way in which information is brought to the committee. She referred to being at a changeover in relation to what comes to the Governance Committee and how it is coming. In particular, she referred to a requirement now that Committee Chairs in their reports to Trust Board detail escalation, meaning that the Committee Chair must take ownership of what the committee is escalating or not escalating[394].

[393] TRA- 09953- TRA 09954 Transcript Day 77 p16-17
[394] TRA-09955- TRA09956 p18-19

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b. She referred to a layer of oversight now present which wasn't previously when asked about the Board or the Governance Committee having any involvement in the outworking of SAI recommendations and ensuring themes of governance that might emerge are dealt with, referring to an action plan being expected and follow up to the Board or the Committee in relation to progress[395].

c. She also addressed the Trust's new process of reporting from MHPS to the Governance Committee, referring to a synopsis of the issues and details of any out-workings and updates which now provides Board visibility into any MHPS processes underway in the Trust.[396]

7.31 In her evidence on Day 78, she provided further examples of improvement including:

a. In relation to separate processes of MHPS, Appraisal, and SAI, and to the joining up of intelligence, she gave evidence about how different things are now.[397]

b. She referred to improvements in reporting aspects of clinical and social care governance including the Champion Review, clinical audit, and unified governance leads.[398]

c. She addressed the learning from a Board governance perspective at WIT-100557 and, in her evidence[399], addressed the issue of culture and her efforts to demystify what the Board is, to take away any view that the Board is a secret place, and to open it up, given its importance to what happens in the hospital.

[395] TRA-09975 p38
[396] TRA-10060- TRA10061 p123-124
[397] TRA-10106- TRA 10107 Transcript Day 78, p4-5
[398] TRA- 10110 Day 78, page 8
[399] From TRA- 10125, page 23

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d. She gave evidence about the positive changes made to the committees of the Trust Board.[400]

e. She spoke about the challenge of, and her efforts in, trying to shift the culture of the leadership walk from one of inspection to one about getting a real sense and feel for what is going on in the unit and to bringing the Board closer to the teams.[401]

f. When asked by Dr. Swart what was the most significant improvement that she has been able to make and what she still thought needed to be done she responded as follows:

> *'I think it's making the Board a collective, responsible Board together. I think that has been achieved in the last three years. My worry list would include having the resources and capacity to deliver and what we need to do to really transform Health and Social Care for the Southern Trust but to effect the changes so that patient safety issues and concerns no longer exist'.*[402]

g. She was also asked by Dr. Swart about lessons learned, whether the right people go to meetings now, whether that is working, and whether she had got to the stage of presenting thematic learning to the full Board for the year and what had been changed. She answered:

> *'I'll take the last one first. We are not there yet, we are not there yet. The outworkings of the Champion review, the operation of governance layer that has been put in place, we are only starting there in terms of that feeding through. My aspiration is it will do just that, it will do just that. But I am hoping over the course of this incoming year we will see that bed in, the committee bedding it in and the teams then certainly being able to feed up what needs to be the focus of attention for the committee and the areas of*

[400] TRA- 10133, p31
[401] TRA-10157, p55
[402] TRA- 10162-TRA-10163, Transcript Day 78, p60-61

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concern and risk. I do get a sense, though, listening to our Directors, because they are a few months ahead of us in terms of their delivery of the operation, that they are being exposed to more than they have ever been exposed and they are unpacking things more than they unpacked before. I am getting a sense that there is a real visibility for them across a broader piece and they are joining dots.'[403]

h. She also, in answer to questions from the Chair about recommendations the Inquiry might make, gave evidence about the burden of work involved in implementing various extant Inquiry recommendations, the resource-consuming nature of that, and her desire to see Trusts supported to deliver that implementation rather than having to place the burden on existing employees with 'already very demanding and difficult jobs'.[404]

Conclusion

7.32 Then Trust hopes that the above overview and guide to some of the main improvement initiatives discussed in evidence before the Inquiry will assist the Inquiry in navigating the broad expanse of evidence that is now before it on the issue of improvements and reforms undertaken by the Trust which should significantly reduce the risk of the problems of the past recurring.

[403] TRA-10164, p62
[404] TRA-10184-TRA-10185 p82-83

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In delivering these responsibilities, I am accountable for the Trust's performance to the Health and Social Care Board (HSCB) and DoH and report through agreed performance management arrangements established for the 2020-21 year including those actions put in place to respond to and subsequently to recover/rebuild from Covid-19 pandemic surge(s). The mechanisms I use to assure myself and Trust Board are below:

- Trust Governance Committee - Provides assurance to the Board on all aspects of the governance agenda (except financial control). This forum brings a range of clinical governance metrics and allows for dynamic triangulation and challenge and scrutiny to be offered by committee members
- Controls Assurance Standards – The Controls Assurance assists in the provision of evidence of the Trust performance to manage in meeting our objectives to protect patients, staff, public and other stakeholders against risks from all sources
- Trust Integrated Governance Framework 2017 - The framework sets out the arrangements for integrated governance within the Southern Health and Social Care Trust for the four year period 2017/18 to 2020/21. It is based on the extant integrated governance strategy 2007 to 2009 which was approved by Trust Board in February 2008 and covers all domains of governance associated with the delivery of health and social care services including corporate governance, clinical and social care governance, information governance, risk management, performance management and financial governance.
- Trust Governance Statement – As part of the Trust Annual Report the Governance Statement provides assurance that the Board exercises strategic control over the organisation through a system of corporate governance which includes:
    - Management Statement and Financial Memorandum;
    - Standing orders including powers reserved to the Board and powers delegated to its Committees and standing financial instructions
    - An Audit Committee;
    - A Governance Committee;
    - An Endowments and Gifts Committee;
    - A Remuneration Committee;
    - A Patient and Client Experience Committee; and
    - A Performance Committee.

The Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services. Committee structures are in place to reflect this integrated approach and to support the Trust Board. The following describes in more detail the role of the Trust Board, its Committee structure and attendance during the reporting period.

In 2019 I commissioned two reviews to provide assurances around clinical governance processes. Having worked in other Trusts I was concerned that the assurance processes were not as robust as I had been used to. In particular the importance of a completely integrated governance system was not as explicit and in my experience felt under resourced. Therefore I progressed with two reviews.

- Trust Board development workshop, 13 November 2019, which consisted of the following elements
    - Board contribution to the Trust's performance
    - Board culture of collaboration, co-production and learning
    - Strategy, Accountability and Culture and Corporate plan priorities
    - Continuing development and collectively leadership on the implementation of the Corporate plan

- 2019 HSC Leadership Centre - Review of Clinical and Social Care Governance (appendix 13) - Health and Social Care (HSC) Leadership Centre undertook an independent review of clinical and social care governance within the Trust, including

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automatically placed on PAS lists depending on the GP grading of risk. On the face of it, this was a failsafe action to protect patients from being lost to follow-up.

71.14 In actual fact, what then happened was that the underlying problem was not addressed, namely the non-triage, and at the same time false assurance was given that because patients were on a list they were safe. In addition, this also served to mask who had been triaged and who hadn't and meant then that, when attempts were made to quantify the breadth and impact of the non – triage, these patients were very difficult to identify and revisit and their outcomes were potentially impacted upon as a result.

71.15 Another example of this appears to have been the limited development and ownership of CSCG processes in the Southern Trust prior to the Champion Review which then led to a system that was challenged in managing patient safety concerns in Urology and which for example had lost its functioning Clinical Audit functions and had at times rudimentary approaches to other CSCG approaches.

71.16 Moving to the specific limbs of Question 71, I address these in the table below.

	Response
Do you think, overall, the governance arrangements were fit for purpose?	I arrived in the Trust on the 1st December. The Acting Assistant Director for Governance Trudy Reid was appointed in January 2019, both of us then assuming key roles in relation to the Corporate aspects of Integrated Clinical and Social Care Governance (CSCG) at around the same time. I was completely new to the organisation and in the course of my induction and orientation was increasingly aware that some of the key functions that were required to assure governance supporting patient safety, were rudimentary. I was concerned whether some of these governance processes were fit for purpose.

I just wonder at the outset if I could ask you, did you get the opportunity to listen to the evidence of Mark Haynes?

A. I listened to all but the last day of his evidence. Yes.

21 Q. Did you listen to the evidence of Dr. Hughes and Dr. Gilbert?

A. I did, yes.

22 Q. I just wonder, given that, is it your view that the Corporate Governance procedures and arrangements within the Trust were effective in highlighting and addressing the concerns raised and known about in relation to Mr. O'Brien given what you have heard so far?

A. When I came to the Trust and started as Responsible Officer effectively from 1st January 2019, I think one of the things I quickly began to discover was that the Governance structure within the Southern Trust was not as robust as it needed to be. On the basis of that, I commissioned a review of the Governance structures, and that took place in the course of 2019. That produced 48 recommendations that The Trust has been working its way through. Certainly we have significantly invested in improving in all of that. I think some of the work that was being done at that point in time, and certainly some of the struggles that we had in terms of bringing together some of the information around Mr O'Brien and other aspects within the Trust, I think highlighted to me that some of the aspects of that, that you would ordinarily expect to be

10:15 10:16 10:16 10:16

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

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

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	improvement.

Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
Governance Committee 5th December 2019	**PRESENTATION: OBSTETRICS AND GYNAECOLOGY** Dr O'Kane presented information on the CHKS Audit and Mortality and Morbidity process within Obstetrics and Gynaecology (O&G). She provided background and a high level summary of statistics including antepartum, C-section and post-partum indicators for CAH and DHH. Dr O'Kane noted her concern the elective C-section rate is higher than the national average and further added that 10% of C-sections were occurring out of hours, which she expected to be higher. The Chair posed a question regarding the possible correlation between increased induction, increased instrumental births and increase in emergency C-sections. It was agreed that C-Section rates will be further explored. ***Action: Dr O'Kane / Mrs McClements / Mrs Trouton*** Mr McDonald highlighted the difficulty in understanding the data presented in the presentation and reiterated the need for increased training for Non-Executive Directors to help an increased understanding in relation to Clinical and Social Care Governance data. In responding to a question asked by Mrs McCartan as regards peer comparisons, the Chief Executive explained the data is not released as a league table, but is a learning tool for the Trust. Complaints were discussed. Dr O'Kane reported the top 4 complaint subjects correlate to the same pattern across other Directorates. Mrs Magwood pointed out an increase in complaints in MHLD and asked if there was a pattern emerging. Mrs Reid advised this quarterly comparison will be ongoing to establish if Directorate patterns are emerging. In relation to Litigation, Dr O'Kane noted between 1999 and 2019, the Obstetrics and Gynaecology division has received 178 claims, of which 140 remain open. Dr O'Kane informed members that a raising concerns process is underway in relation to a whistleblowing complaint. NIMDTA have commenced a review in response to concerns raised by Doctors in training. Dr O'Kane added management will be meeting	Appendix 45 – OG Timeline Paper 01

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Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	with staff to gain a better understanding of the issues which will be carried out in a confidential setting with staff. Dr O'Kane proposed to the committee the trusts intention to request an Invited Service Review from the Royal College Obstetricians and Gynaecologists. Mrs Reid guided members through the Morbidity and Mortality process within Obstetrics and Gynaecology and drew members' attention to the meeting structure. She reported on the number of outstanding perinatal and maternal deaths that are awaiting sign off. The Chair thanked Dr O'Kane and Mrs Reid for an informative presentation.	
Governance Committee 13th February 2020	**<u>Matters arising</u>** Members noted the progress updates from the relevant Directors. In relation to the action on the trends within Obstetrics and Gynaecology, Dr O'Kane advised the NIMATS regional maternity dashboard data for 2019/20 is awaited. Following an in depth discussion it was requested the data be presented at the next meeting to include information on induction, instrumental births, elective C-section rates and post op haemorrhage. Dr O'Kane advised that the Trust was now not proceeding with an Invited Service Review from the Royal College of Obstetricians and Gynaecologists. ***Action: Dr O'Kane / Mrs McClements / Mrs Trouton***	
Governance Committee 14th May 2020	**<u>Matters arising</u>** Members noted the progress updates from the relevant Directors. Dr O'Kane confirmed that the Invited Review within Obstetrics and Gynaecology would be proceeding and she would update at the next Governance Committee meeting in September 2020.	

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	In relation to Obstetrics and Gynaecology NIMATS Regional Maternity Dashboard, Dr O'Kane provided a verbal update. She advised a Quality Improvement programme for Post-Partum Haemorrhage (PPH) has been undertaken. There has been a change in staffing and there is an increased presence of Consultants available. She noted the PPH rate is higher than expected in Daisy Hill Hospital and work is underway to gain a better understanding on the reasons behind this. Dr O'Kane commented that this will further be discussed at the September meeting when a presentation will be provided on the dashboard.	
Governance Committee 10th September 2020	**<u>OBSTETRICS AND GYNAECOLOGY IMPROVEMENT WORK</u>** The Chair welcomed Dr Aoife Currie, Clinical Director to the meeting. Dr Currie thanked members for the opportunity to present on Post-Partum Haemorrhage (PPH) improvement work and the Regional Maternity Dashboard (NIMATS April 2019 – projected March 2021).	Appendix 45 – OG Timeline Paper 02 & 03
Governance Committee 26th November 2020	**Invited Review within Obstetrics and Gynaecology** Dr O'Kane reminded members that that the Royal College of Obstetrics and Gynaecology (RCOG) had previously indicated that they did not have the capacity to undertake a review, however, she agreed she will contact the RCOG for an updated position and feedback at the next meeting. ***Action: Dr O'Kane*** **O&G Whistleblowing Investigation** Mrs Toal referred members to the written update which advises that a draft report has been received from the Independent Investigation Team. She noted that the draft report did not highlight any significant individual clinical performance concerns or safety concerns, however it emphasised	

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Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	significant concerns in respect of midwifery staffing levels, and issues around culture in the service, both of which the service is already working hard to address. Mrs Toal assured members that the final report on actions and lessons will be provided for the next meeting. ***Action: Dr O'Kane / Mrs Toal***	Appendix 45 – OG Timeline Paper 04
Governance Committee 11th February 2021	**Matters Arising** **REPORT ON OBSTETRICS AND GYNAECOLOGY WHISTLEBLOWING** **INVESTIGATION – key actions and learning** Mrs Toal presented a report outlining a number of key actions and learning from the investigation raised in respect of the Obstetrics and Gynaecology Whistleblowing Investigation. She informed members that the report of the investigation, which commenced in January 2020, has still to be received and accepted in its entirety by the Trust's oversight group. This is being followed up by the Medical Director and the Executive Director of Nursing, Midwifery and AHPs to seek to bring to a satisfactory conclusion. Mrs Toal recognised that this has been a very difficult and protracted investigatory process which has been impacted by pressures of Covid-19. Dr O'Kane spoke to the key concerns raised in the report and stated that the Investigating Team reported that it was satisfied that clinical competency both of Obstetricians and Midwives met the required standards. Specific cases referred to in the correspondence raising issues in relation patient safety / obstetric violence have been independently reviewed through case note reviews / interviews and no significant issues were evidenced. Dr O'Kane commented to ensure that safe maternal care is in place additional support has been put in place to support governance arrangements and the team has reviewed their processes for analysing Stillbirths / Neonatal Deaths and developed the Perinatal Mortality Review Tool (PMRT). This tool is being trialled and it is envisaged that the outcome will be presented at a future	Appendix 45 – OG Timeline Paper 05

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Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	Governance Committee meeting. Mrs McCartan thanked the Directors for their update on this issue and welcomed the positive initiatives being undertaken to address these matters. She asked if the issues were management related. Mrs McClements stated that a service improvement action plan had already been established to improve quality and patient experience prior to this Whistleblowing investigation and work is ongoing with positive impacts already noted. She did highlight that there were specific issues in relation to the Delivery Suite, and management undertook significant work to address these concerns. There may have been earlier opportunities to address some of these issues. In response to a question asked by Mrs McCartan, Mrs McClements confirmed that performance appraisals are undertaken through 1:1 supervision built into staff practice. Mr Wilkinson asked for further information on the process of undertaking factual accuracy of the report. Mrs Toal explained that applicable extracts of the report had been shared with those individuals involved for their comments. She reported that there were numerous inaccuracies throughout the report and these have been fed back to the investigation team. Ms Donaghy queried if patients were interviewed and complaints reviewed to inform the investigation. Mrs Toal advised that service user stories were included as part of the initial whistleblowing concern, however there were concerns on the source of this information. Mrs McClements added that patient experience has been captured from discharge questionnaires. In some instances, patients have indicated that they are aware of the demands on midwifery staff and the increasing staff shortages. She advised that a piece of work is ongoing to address how staff are perceived as busy to patients on the ward. In responding to a question asked by Mr McDonald, Mrs Toal confirmed that the Trust has in place the HSC values and behaviours that all staff have signed up to. She noted that there have been shortfalls in these values	

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Q23 - Issue 1: Obstetrics and Gynaecology Whistleblowing Investigation		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	highlighted by the investigation team and this is a piece of work that the teams are taking forward to improve across the division. Members requested that the final report be presented at a future Governance Committee meeting when available.	
Governance Committee May 2021	Matters Arising - O&G Whistleblowing Investigation Members were advised that a summary report on the investigation was being finalised and would be issued for discussion at their next meeting with the Chief Executive on 17th May 2021.	
9th September 2021	Matters arising – O&G Whistleblowing Investigation Confidential briefing held with Non-Executive Directors on 17th May 2021. Copy of updated Action Plan shared with Non-Executive Directors - attached .	Appendix 45 – OG Timeline Paper 06

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
Confidential Trust Board 29th March 2018	PM & JTK Mrs Harney referred members to the written update on the incident involving the alleged assault of a patient by nursing staff in Bluestone. She advised that the NMC initial suspensions will continue for both registrants until the PSNI/criminal procedures are concluded.	Appendix 45 – Dorsy Paper 07
Confidential Trust Board	PM & JTK Mrs Harney referred members to the written update on the incident involving the alleged assault of a patient by nursing staff in Bluestone. It is	Appendix 45 – Dorsy Paper 08

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	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
7th June 2018	envisaged that dates for Crown trial will be set out at the Preliminary Enquiry on 8th June 2018 and the PSNI have indicated that they envisage significant media interest on this date. The Trust Communications Team are fully aware of this. She advised that the NMC initial suspensions will continue for both registrants until the PSNI/criminal procedures are concluded.	
Confidential Trust Board 27th September 2018	Bluestone and Dorsy Workforce Pressures The Chief Executive stated that this service pressure is a standing item on the SMT agenda and there has been proactive engagement with RQIA and steps taken to address the challenges. Mrs Harney advised that a workforce plan is in place up to December 2018. The Chair asked that in light of this staffing pressure, if other services were being stood down. Mrs Harney advised that some resources from routine elective work within community mental health teams was re-directed to in-patients. Mrs Trouton gave assurance that safe patient care was being maintained in Bluestone and Dorsy. Discussion ensued in which members raised concern at the impact workforce pressures are having on the delivery of Trust services, particularly in the wider mental health area. At the suggestion of the Chief Executive, members agreed to write as a Trust Board to the Department in relation to workforce planning.	Appendix 45 – Dorsy Paper 09
Confidential Trust Board 25th October 2018	Bluestone and Dorsy Workforce Action Plan The Chief Executive stated that this service pressure continues to be a standing item on the SMT agenda to address the recovery/control plan. A Trust Directors Oversight Group and a sub-group structure have also been established. Mrs Harney spoke to the written summary update. She advised of the implementation of a phased approach to the workforce plan for Bluestone and Dorsy and stated that a short term immediate action plan has been implemented, that medium to long term actions were discussed by the SMT the previous day with agreement to bring a draft paper to SMT for an investment proposal to be discussed with the HSCB and the PHA on 7th December 2018.	Appendix 45 – Dorsy Paper 10

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	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	Mrs Harney reported that Leadership walks are ongoing and that staff feedback from community workforce input to the in-patient wards has been positive. The Chair referred to the RQIA/Trust 'serious concerns' meeting on 12th October 2018 and asked that outside RQIA visits/inspections, would Trust senior management have picked up any culture issues in the units during leadership walks. Mrs Harney provided assurance that leadership walks have always been a part of practice in MHLD albeit a formal template is not completed. She stated that Dorsy has become a long stay unit with a cohort of complex patients and this has created a difficult and challenging environment for patients and staff. Mr Wilkinson made the point that culture is dynamic and will change with the patient population. He raised concern about the perception of the Heads of Service and Assistant Directors with regard to a change in culture, as they are key to action being taken. Reference was made to the regional review undertaken by Mary Hinds and Mrs Leeson asked that this report would be shared with members and this was agreed. Mr McDonald welcomed the proposal to use some of the Directorate's allocation to meet staff resourcing costs and asked about the amount available. Ms O'Neill advised that the process was being worked through and agreement would be sought from the Commissioner to use some of the mental health allocation to take forward some of the actions. The Chief Executive concluded the discussion by advising that once this service pressure was identified, a series of actions were put in place quickly. Staff understand the need for change and the next step is to ensure the resourcing of some of these actions.	
Confidential Trust Board 29th November 2018	Bluestone and Dorsy Workforce Action Plan The Chief Executive stated that this service pressure continues to be a standing item on the SMT agenda with the focus now on medium – long term actions. Mrs Harney spoke to the progress update and highlighted the key actions. She advised that SMT has approved 17 Band 5 uplifts to Band 6 using the available mental health non ring fenced budget allocation to create a more senior profile on the inpatient wards. SMT has also approved securing Mental Health/Learning Disability workforce from England to	Appendix 45 – Dorsy Paper 11

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	facilitate the required cover over holiday/winter periods. Members noted the Trust/HSCB/PHA meeting scheduled for 7th December 2018 to agree a joint approach to achieving the normative staffing levels within the in-patient mental health units. Mrs Leeson commented on the fact that the Executive Director of Nursing/AHP led professional governance audits have demonstrated safe and effective care and queried why staff do not want to work in the in-patient wards. Mrs Harney stated that the workforce pressures have arisen due to the fact that junior staff have moved to more senior posts in the community and it is hoped that the creation of a more senior staffing profile in the inpatient wards will address this issue. Mrs Harney also spoke of the active engagement/co-production/workshops with ward managers and front line staff to seek their views on support systems to maximise workforce recruitment and retention within Bluestone, making it an attractive place to work. Mrs Trouton provided some examples of actions that are being actively progressed with the Executive Director of Nursing/AHPs professional team input. The Chair asked if there was recognition at Department level that insufficient numbers of nurses were being trained to which Mrs Trouton advised that the Trust continues to work with the Department to influence an increase to the supply of registered nurses with an increase of 200 places across nursing and midwifery since 2016. Mrs McCartan asked if the pay award for 2018/19 would assist in attracting people to nursing. Mrs Toal stated that from a pay award point of view, Northern Ireland is still behind the rest of the UK, particularly in relation to nursing pay scales. Ms Mullan referred to the continued pressures across various sections of the workforce and the increasing cost of the flexible workforce and raised the need for a broader Northern Ireland skills agenda for the public sector.	
Confidential Trust Board 24th January 2019	Bluestone and Dorsy Workforce Action Plan Mr McNeany spoke to the progress update and advised that medium and long term actions are in place and monitored by the Directors' Oversight Group. Mr McNeany referred to the workforce pressures and in response to a question on the use of agency staff, he advised that the agency staff secured from England, together with use of bank staff and overtime, has eased the staffing pressure on the Acute Wards and had allowed community	Appendix 45 – Dorsy Paper 12

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	staff to return to their community teams. The plan is to continue to use agency staff to 31st March 2019 to provide a sufficient workforce. Members noted the continued engagement exercises with permanent staff, staff side representatives and agency/bank personnel to identify improvements.	
Confidential Trust Board 28th March 2019	Royal College of Psychiatrists Invited Review The Chief Executive spoke of the Invited Review process the Trust is intending to undertake with the Royal College of Psychiatrists in April 2019 to look at the in-patient mental health service and potential improvement plans. Mr McNeany explained the background to the review which he stated would provide further independent assurance as to the safety and effectiveness of the service. The Invited Review will consider the existing service model and present recommendations for service modernisation. The invited review is likely to take three months and the outcomes will be reported to Trust Board in August 2019. Members discussed the Terms of Reference and particularly the review of culture within the in-patient mental health service. They welcomed the direction of travel and the Trust's open and transparent approach to this work. Communication with staff about the review was raised to which Mr Neany explained that a communication plan was in place and staff were being spoken to that morning. Mrs Toal stated that she felt sufficient supports have been built into the process to respond to any concerns and to provide assurance.	Appendix 45 – Dorsy Paper 13
<u>Public</u> Trust Board 28th March 2019	Building a Progressive Inpatient Mental Health Service The Chief Executive informed members of an Invited Review process the Trust wishes to undertake with the Royal College of Psychiatrists in April 2019 to look at the in-patient mental health service and potential improvement plans.	Appendix 45 – Dorsy Paper 14

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**

Mr McNeany explained the background to the review which he stated would provide further independent assurance as to the safety and effectiveness of the service. The Invited Review will consider our existing service model and present recommendations for service modernisation. The invited review is likely to take three months and the outcomes will be reported to Trust Board in August 2019.

Mr Wilkinson asked if the review will look at access to mental health services to which Mr McNeany advised that as the focus will be on the inpatient service it will consider points of entry and discharge to and from Bluestone, Dorsy and Gillis as part of the overall service model review. In response to a question asked by Ms Mullan, Mr McNeany confirmed the team will meet with him on a daily basis to provide feedback. Mr McDonald welcomed the Trust's open and transparent approach to this work and asked how they plan to measure the culture within the system. Mr McNeany responded by advising that the Royal College of Psychiatrists have a Centre for Quality Improvement which has developed standards using co-production that are subject to peer accreditation. Mrs Leeson enquired if staff have been informed of this review. Mr McNeany advised they were being briefed that morning. Mr McNeany noted staff and staff side will have an opportunity to meet with the review team.

The Chair requested that an update would be provided at the next meeting in May 2019 with the report being presented to Trust Board in August 2019.

Public Trust Board 23rd May Matters arising

Item 8iii) **Building a Progressive Inpatient Mental Health Service**	Request for progress updates with final report to be brought to a	Mr B McNeany	Report to be provided for 29th August 2019 meeting.

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	future Trust Board meeting.	
Public Trust Board 29th August 2019	Royal College of Psychiatrists Invited Review At the outset, the Chief Executive set the item in context and reminded members the Trust had recently undertaken an Invited Review process with the Royal College of Psychiatrists to look at the in-patient mental health service and potential improvement plans. He stated the review had considered the organisation's existing service model and presented recommendations for service modernisation and improvement. Members noted that in response to the Invited Review Report, an Action Plan has been agreed to address the main recommendations and this has been shared with the Health and Social Care Board (HSCB). In addition, a number of other improvement approaches identified from staff engagement activities and service user feedback will be taken forward. At this point, Mr McNeany updated members on progress post review. He stated work streams aligned to the recommendations are progressing, with a clear focus moving forward and work is underway along with Planning and Reform/Finance Directorates in terms of service development. Ms Donaghy welcomed the additional independent external assurance into In-Patient Mental Health Services in Bluestone/Dorsy & Gillis Units provided through the Invited Review Report and particularly the commencement of the workforce plan. Mr McNeany reminded members workforce resources continue to be a challenge and stated consideration was being given to in-house training options and collaborative working with the Open University. Mr Wilkinson asked how the Trust will measure progress against the Review. Mr McNeany advised the Lead Reviewer will re-visit the Trust in 6 months and ongoing review of the Action Plan will be taken forward through the Directors Oversight group. Mrs Trouton spoke to the nursing workforce supply issues and Mr Douglas updated around the shortage of trained social workers and options being	Appendix 45 – Dorsy Paper 15

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	explored to address this. In concluding discussion, members welcomed the independent external assurance provided through the Invited Review Report and noted that further progress will be provided to Trust Board in a timely manner.	
Confidential Trust Board 26th September 2019	<u>EXECUTIVE SUMMARY PAPER ON THE ROYAL COLLEGE OF PSYCHIATRISTS INVITED REVIEW</u> Mr McNeany spoke to the paper. He advised that the 52 recommendations have been collated into an overarching action plan and the Director's Oversight Group will be responsible for the monitoring of progress. Members welcomed the action plan and asked a number of questions. Ms Donaghy made reference to previous RQIA inspections and asked if the Review Team made any comments with regard to the roll out of the recommendations. Mr McNeany advised that this information has been shared with the Review Team, but was not factored into their findings. Ms McCartan particularly welcomed the work with Merseycare Trust in terms of learning from other Trusts and asked about the timescale of the action plan objectives. Mr McNeany advised of a 12- 18 month timescale on the basis of successful recruitment and retention of staff. He added that to fully embed all recommendations requires a full multi-disciplinary team and stated that the availability of a suitably qualified and available workforce continues to be a significant challenge for Bluestone, Gillis and Dorsy as it does for every in-patient mental health service in Northern Ireland. Mrs Keenan raised staff shortages and the requirement for additional staff and asked what initiatives were in place to retain staff. Mr McNeany spoke of the worklife balance opportunities and the learning from exit interviews with staff. He noted the challenges in providing a 24 hour service and stated that one area that was identified in the review was how to respond to incidents, particularly with regard to staff suspended due to safeguarding issues which often took a very long time. Mr McNeany advised that he would provide a report on performance against the action plan objectives at the Trust Board meeting on 30th January 2020.	Appendix 45 – Dorsy Paper 16 & 17

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
Confidential Trust Board 17th June 2021	The Chief Executive spoke of the journey the Trust has been on over the last few years to be curious and increase the culture of 'See Something, Say Something' across the Organisation. He reminded members of issues in Dorsy in 2020 when an Early Alert was raised in relation to physical interventions by various members of staff of a patient in seclusion and advised that further information has come to light in the last few days as the investigation process progresses. Mrs Woolsey provided a verbal synopsis of the situation. She stated that the Joint Protocol Adult Safeguarding investigation with the PSNI remains live. As the investigation has progressed, further information has been made available in the form of two expert reports provided to the PSNI. She advised that the Trust took the decision the previous day to place a Registered Nurse on precautionary suspension from 17.6.2021. From the initial uncovering of concerns, a member of staff remains on precautionary suspension and other members of staff have had various restrictions placed on their working practices. In addition, the Ward Sister tendered their resignation this week due to personal circumstances unconnected to this investigation. The PSNI has indicated their intention to interview seven staff members under caution with regard to the Joint Protocol investigation. Mrs Woolsey stated that the patient has been discharged from Dorsy and has settled well in the Meadows. The service user's mother has been kept informed and invited to Strategy meetings but has declined to attend. Members asked if any concerns about interventions with other patients had been raised. Mrs Woolsey advised that as a result of CCTV footage in relation to this incident, a physical intervention with another patient entering seclusion was observed, but this case was now closed. Mrs Woolsey also advised that an anonymous letter had been received in December 2020 which Adult Safeguarding investigated and is on hold as the member of staff referenced in the anonymous letter could be assumed to be the same individual who is suspended relating to the Joint Protocol investigation. In response to a question on staffing, Mrs Woolsey acknowledged the ongoing challenge of staff cover in the mental health in-patient units. She provided assurance that the staffing situation in Dorsy is closely monitored and temporary solutions such as bank and agency usage is in place. Mrs Toal spoke of the potential risk to service continuity once staff become	Verbal Update No Paper

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	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
	aware that they would be interviewed under caution and Mrs Woolsey acknowledged the potential need to put in place a contingency plan for Dorsy to ensure service continuity. Ms Donaghy referred to those staff involved in this incident and asked if there were any issues raised in their performance management reviews. Mrs Woolsey advised that she was not aware of any issues. Mrs Woolsey raised the Royal College of Psychiatrists Invited Review report and spoke of the significant action plan in place to take forward recommendations. Mrs Woolsey outlined the good work and improvements made in Dorsy and reminded members that the Invited Review identified no episodes of patient harm. Members discussed the risk that this incident would come into the public arena and Mr McDonald emphasised the importance of the communications message. The Chief Executive stated that Mrs Woolsey and team are working closely with the PSNI under the Joint Protocol and in the event of any public communication from the PSNI, members will be kept informed. It was agreed that an update would be provided at the next confidential Trust Board meeting on 30th September 2021.	
Confidential Trust Board 26th August 2021	Dr O'Kane provided a verbal synopsis of the situation since the previous update to Trust Board on 17th June 2021. She advised that seven staff members are now being interviewed under caution by the PSNI with regard to the Joint Protocol investigation. Dr O'Kane spoke of the good work and improvements made in Dorsy and the establishment of the Oversight Group. It was agreed that an update would be provided at the next confidential Trust Board meeting on 30th September 2021.	Verbal update No Paper
Confidential Trust Board 30th September	Dr O'Kane spoke to a paper which explores the Intellectual Disability service model currently being provided at Dorsy Unit detailing issues identified within the service, causative and contributory factors that have enabled the issues to manifest and actions that have been taken to safeguard service	Appendix 45 – Dorsy Paper 18

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
2021	users and staff who reside and work in the unit. Dr O'Kane drew members' attention to a range of actions that have been undertaken, as outlined in the paper, to improve the service and ensure the safety of patients and staff. She stated that improvements are being made at pace on the culture and environment in unit and enhanced efforts to increase staff recruitment enacted. Mr Wilkinson raised the challenge of Dorsy unintentionally becoming a 'long stay' Unit and asked if practices changed as that purpose evolved and sought assurance that there was a now a good understanding of the overall situation. Dr O'Kane spoke of the establishment of an overarching inpatient governance group to oversee existing sub groups for Bluestone and Dorsy and the weekly oversight group for Dorsy Unit with Directors input to support ongoing safety and service improvement activities. She referred to the regional ID service model and the challenges in meeting the needs of patients and acknowledged the pressures on the unit due to the need to provide care for patients from other Trust areas. Dr O'Kane advised that the Trust is pursuing a regional and local review of the ID service model. In relation to safeguarding issues and investigation, Dr O'Kane advised that police interviews with some staff under the Joint Protocol were progressing. The Chair stated that she was assured by the actions taken and the processes put in place by Dr O'Kane and the team to address the issues and improve the service. It was agreed that a progress update would be provided at the next confidential Trust Board meeting on 28th October 2021.	
Confidential Trust Board	Dr O'Kane drew members' attention to a range of actions that continue to be undertaken to improve the service and ensure the safety of patients and staff. She particularly highlighted the Psychological Environment	Appendix 45 – Dorsy Paper

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

	Issue 2 : Emerging Issue in Dorsy & Mental Health	
Where and when presented	**Minute Extract**	**Report attached (reference)**
28th October 2021	improvements and advised that a Divisional Nurse and Lead Nurse for Mental Health will relocate to Dorsy immediately to address nursing leadership, nursing morale, nursing management of patients and environment as a matter of urgency. She stated that there will be an emphasis on working with ID colleagues to develop a culture of enablement, rehabilitation and positive behavioural support and risk taking (Therapeutic Community ethos). In respect of the physical environment, Dr O'Kane advised that short term improvements continue to be made with work focused on maximising what space is already there. Mrs Leeson welcomed the positive changes and asked about the progress of a review of the ID service model. Dr O'Kane acknowledged the challenges of the current model in meeting the needs of patients as well as the pressures on the unit due to the need to provide care for patients from other Trust areas. She advised that this issue was again raised at the regional Directors Oversight Group the previous week. In relation to safeguarding issues and investigation, Dr O'Kane reported that voluntary police interviews with 7 staff have been completed.	19

Issue 3 : Update on Investigation into Dr A's Concerns		
Where and when presented	**Minute Extract**	**Report attached (reference)**
Confidential Governance Committee 11th May 2018	The Chief Executive explained that Dr A had been on Personal Information [redacted], but was now back at work. A meeting with Dr A has been arranged for end May 2018. The Chief Executive stated that the names of 3 Consultant colleagues willing to sit on a Panel to look at a sample of incidents (including Dr A's) are awaited from Dr A.	Verbal update No paper

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Issue 3 : Update on Investigation into Dr A's Concerns		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	Members asked that this item remains on the agenda for an update at the next meeting.	
Confidential Governance Committee 6th September 2018	Dr Khan advised a meeting with Dr A took place in May 2018. He noted the three Consultant names had been received. They will sit on a panel to review a sample of incidents and they will be supported by the Corporate Governance team. The purpose of the review will be to examine the internal process of reporting adverse incidents within the Trust. Dr Khan stated the group are in the process of producing Terms of Reference. Following a question by Mrs Rooney the Chief Executive agreed the Terms of Reference will be shared with members once approved. Mr McDonald highlighted the importance to link the learning identified from this investigation to the Lessons Learned Committee to which Dr Khan agreed. In responding to a question posed by Mrs Rooney, Mrs Trouton advised the timeframe to review a number of sample incidents will be from 2013 onwards. Dr Khan assured members Dr A's incidents, which he reported in that timeframe, will also be reviewed. The Chief Executive stated the issue of reporting incidents is not solely an IT issue but how the Trust process is carried out when examining incidents and this is the main concern that will be reviewed during this investigation. The Chair asked if Dr A was satisfied with the progress of the investigation to which Mrs Toal and Dr Khan both agreed they felt he was content following the discussions.	Verbal update No paper

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Issue 3 : Update on Investigation into Dr A's Concerns		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	Members asked that this item remains on the agenda for an update at the next meeting.	
Confidential Governance Committee 6th December 2018	Mr Devlin referred members to the update in their papers on the work of the adverse incident review group tasked with reviewing Dr A's concerns in respect to adverse incident reviews. Members were advised that the second meeting of the group took place on 26th October 2018 when the Terms of Reference of the adverse incident audit were agreed. Mrs H Trouton, is a member of the group, and she reported that the audit process has started and it is hoped to complete this by end January 2019. The Chair asked if Dr A was content with the progress of the investigation to which she was advised of discussions with Dr A to ensure he was content. Members asked that a short paper outlining the key themes from the adverse incident audit is brought to the next meeting.	Appendix 45 - Dr D Paper 20
Confidential Governance Committee 7th February 2019	Dr O'Kane provided a verbal update on the initial outcomes of the work of the adverse incident review group. A written report will now be produced for the next Governance Committee meeting and shared with Dr A also. Dr O'Kane reported that the overall sense is that there is appropriate and accurate recording of incidents at a level of 80%. There is room for improvement in terms of how learning from incidents is communicated. Mrs Trouton, who was a member of the review group, stated that one of the tasks of the adverse incident audit was to look at the downgrading of incidents and she confirmed that there was no evidence of systemic inappropriate downgrading of Datix incidents. She	Verbal update No paper

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Issue 3 : Update on Investigation into Dr A's Concerns		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	reported that of the 24 cases reviewed (8 from Dr A and 16 randomly selected), where changes were made to the grading of severity, 80% of the responses indicated that these changes were appropriate. Mrs Rooney noted the 80%, but stated that it was important not to ignore the 20% and the room for improvement.	
Confidential Governance Committee 21st May 2019	The Chief Executive advised that the process has now been completed and he referred members to the update on thematic actions in their papers. Dr O'Kane spoke to the key themes and stated that it was important to note the finding of the look-back exercise that there no systemic concerns raised regarding the downgrading of incidents. Mr McDonald welcomed the new approach to provide further involvement from clinical staff at the Lessons Learned Committee. The new regional report on policy and procedures for reporting and management of Adverse Incidents (May 2019) was referenced and the importance of this being incorporated into the Trust process was highlighted. In terms of the next steps, Mrs Toal confirmed that she has made contact with Dr A and a meeting with him will take place over the coming weeks when the report and themed outcomes will be shared with him. The Chair stated that this will conclude this process and the Committee will be updated at its next meeting in September 2019 to confirm same.	Appendix 45 – Dr D Paper 21
Confidential Governance Committee 5th September 2019	Dr O'Kane informed members she met with Dr A along with Mrs Toal on 27th June 2019. She informed members the report and themed outcomes were shared and discussed with Dr A and advised he was content with the response from the Trust on his concerns. Mrs Toal assured members the action plan and recommendations will be followed through by the operational teams under the normal procedures.	Appendix 45 – Dr D Paper 22

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Issue 3 : Update on Investigation into Dr A's Concerns		
Where and when presented	**Minute Extract**	**Report attached (reference)**
	The Chief Executive advised that the process has now been concluded.	

Q24	**In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.**
Response	As Chief Executive I am a member of Trust Board therefore my engagement is from within, Trust Board is not separate from me. Formal Engagement takes place through 1. Monthly Trust Board meeting 2. Governance committee 3. Audit committee 4. Trust Board workshops 5. Non Executive briefings – weekly during Covid pandemic, now monthly 6. Remuneration committee 7. Ad hoc briefings Informal 1. Weekly meetings between Chief Executive and Trust Chair 2. Chair and Chief Executive both have an open door policy and our offices are in the same corridor. Therefore there is a constant opportunity to meet informally, and we do.

Q25	**Who on the Trust Board has responsibility for clinical governance and patient safety? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* since September 2016.**
Response	The Director with responsibility for Clinical Governance and Patient Safety is the Medical Director, whose Job Description is at appendix 21. Questions 10, 11, 12, 20 and 23 articulate how the board gains oversight of clinical governance and patient safety. The Board Assurance manager during my tenure has been Sandra Judt, whose Job Description is at appendix 22.

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Southern Health and Social Care Trust

Consultation on Proposed Structures for Clinical and Social Care Governance

Consultation Period 8th Dec to 22nd Dec 2010

"A SYSTEM OF TRUST"

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

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SECTION 1: Context

Introduction

In September 2010 the Trust Governance Committee approved the initial findings and recommendations of the Review of Clinical & Social Care Governance. The document, previously circulated, (see Appendix I) recommended a model for clinical and social care governance (CSCG) within the Southern Trust and the rationale for the proposed model. This consultation document is an addendum to the review, summarising it, but with the specific purpose of proposing how the review recommendations could be translated into new organisational structures which would deliver high quality CSCG and with the aim of consulting the wider workforce on these structural proposals.

Background

The Southern Health and Social Care Trust (the Trust) is committed to **providing safe, high quality care**. Key to the achievement of safe, quality care is effective structures, systems and processes to ensure that standards for services, care and our workforce are agreed, understood, implemented monitored and reported, and that where these standards are not met, this is known at all levels in the organisation and effective actions are taken to address any gap and manage any resultant risks.

In the current and future environment, with increasing standards for safety and quality of care, rising public and political expectations and reducing resources, it is even more important that Trust Board and staff at all levels are focused on the delivery of safe care; that there are systems in place to measure and assure our compliance with key standards, and systems and processes to quickly and effectively address any gap in compliance which could impact on the delivery of safe care. Where compliance is not possible within our resources, it is equally important that the Trust understands the constraints in

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achieving compliance and the resulting risks, effectively communicating these both internally and to our commissioner and DHSSPS.

Service Reviews from England and elsewhere have highlighted organisational and practice issues which have resulted in poor quality, and in some cases unsafe care. The Mid Staffordshire NHS Foundation Trust Inquiry and the resultant reports provide an important framework against which to judge our capability to provide safe, high quality care.

It is in this context that the Senior Management Team of the Trust commissioned a review of CSCG arrangements within the Trust.

Purpose and Objectives of Review

The review was commissioned by the Acting Chief Executive and SMT in March 2010 with the remit to critically appraise the Trust's current operational and assurance systems in relation to CSCG, including processes, capacity, capability and outcomes from the current system (see Appendix 2 for Terms of Reference).

Methodology

The Review, while intending to satisfy its terms of reference and benchmark the organisation against the findings of Independent Inquiries in other Trusts, for example the Mid Staffordshire Inquiry, adopted a very basic and fundamental template on which to assess the current CSCG system and make recommendations for improvement. Four basic questions were considered in the examination of the current roles, responsibilities, accountability arrangements and systems, and the resolution of these questions shaped and informed the Senior Management Team (SMT) recommendations:

1. What does the Trust mean by clinical and social care governance – what are its components?
2. Who is responsible and accountable for delivering these components?
3. How does the Trust deliver these components?

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4. What products does the Trust get from these components, and will these products address the findings and recommendations of other Inquiries?

The methodology adopted within the Review considered each of these questions against the current position and derived recommendations for improvement, based on best practice literature and interviews with all key staff groups including the Medical Directorate and the CSCG team within that, professional governance staff from Medicine, Nursing, Social work and Allied Health Professionals (AHP's) and operational staff from all Directorates and all disciplines. The emerging issues and associated professional views were presented to SMT on an ongoing basis and worked through in a series of SMT workshops. The recommendations emerging from these workshops were endorsed by the Trust Governance Committee in September 2010 and have formed the basis of this consultation document.

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SECTION 2:

Rationale for Change

During the review, while within the Southern Trust it was evident that although there were no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues emerged. Through a series of workshops SMT produced recommendations and developed a pathway for change and improvement to the CSCG systems and processes within the Trust. The recommendations are summarised below:

- Effective decision making on issues of safety and quality should be taken as close to the point of service delivery as possible.
- Clarity and singularity of responsibility and accountability are required with respect to CSCG within the organisation.
- An in-depth understanding and agreement of the 'professional' Executive Director role and responsibilities, to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP). They will also independently assess and provide assurance on the levels of compliance to SMT Governance and Governance Committee, while providing a corporate alert when compliance with standards is at an unacceptable level.
- The operational management of services carries the responsibility and accountability for the safety and quality of those services and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters.
- Service teams have a clear understanding of the roles and responsibilities within the organisation for clinical and social care governance. They have both confidence and ownership of their role, combined with the support mechanisms to provide the capacity for them to respond to the current and increasing CSCG agenda.

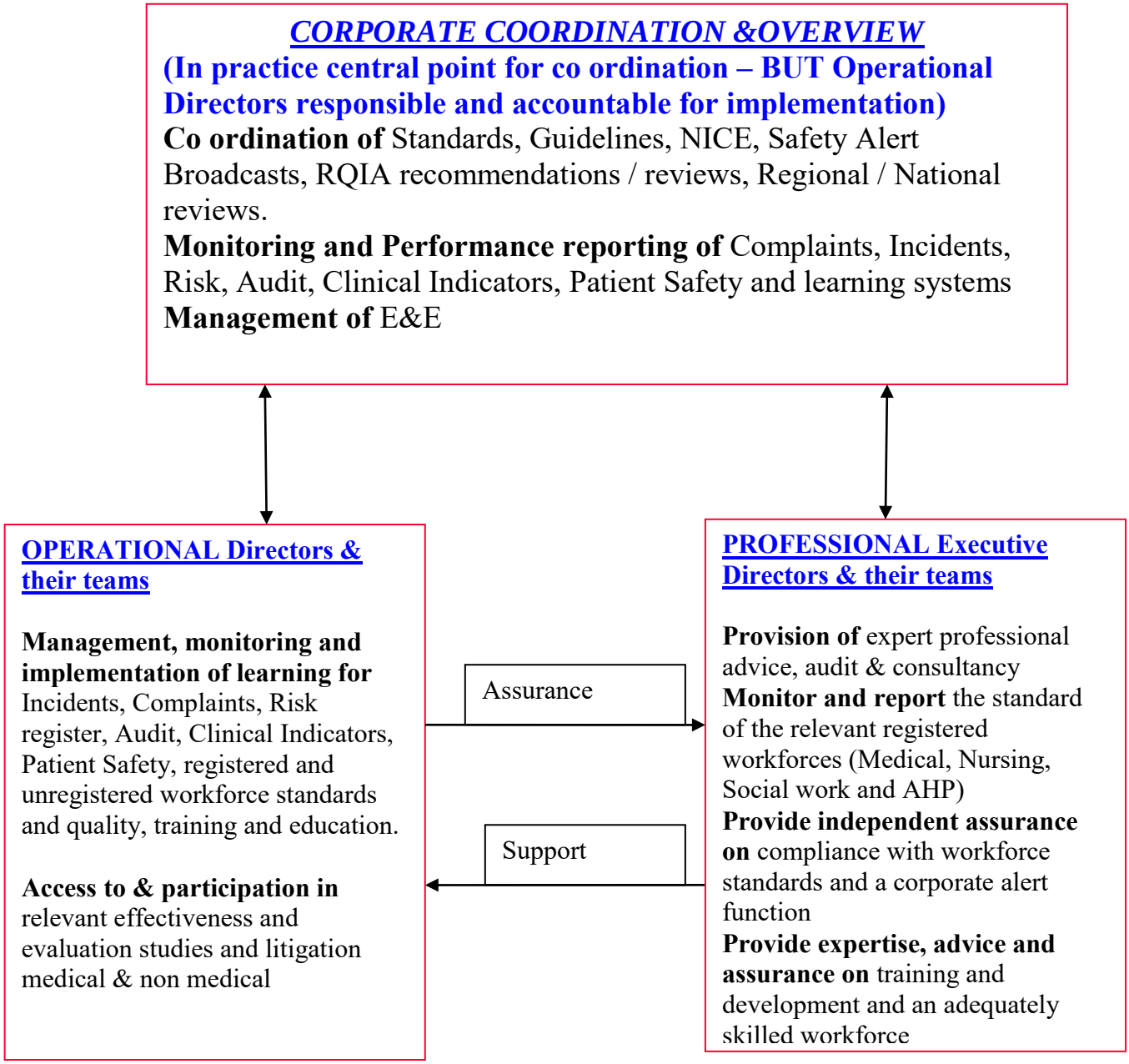
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- Clear arrangements are needed to ensure shared learning across the organisation.
- Effective organisational intelligence is critical to the identification and effective management of patient and client safety and service quality, and this must be available both corporately and at all levels in the organisation.
- These principles are underpinned by the organisation's continued commitment to a culture of openness, transparency and fairness.

In order to achieve these recommendations the SMT agreed a model of CSCG with three clear core components

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Three Core Components of CSCG



In order to meet the recommendations from the review and achieve the above model of CSCG where appropriate safety and quality actions happen in real time, at the frontline, by the people involved in service delivery who are given the means to make and effect change, the current central structures of CSCG need to be decentralised and supported by an improved information management system accessible by all frontline staff. The proposed changes to the current structure are outlined in Section 3.

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SECTION 3:

Proposed Structures

Within this section the three core components of the Trust CSCG model have been populated with the proposed structure to deliver them. How the new structure will actually work in practice is then described. It is essential that the concepts described earlier – decision making as close to the point of service delivery as possible by those who can effect change and learn from it, clarity and singularity of accountability, communication and Trust wide patient safety learning and organisational intelligence are the foundations of how the CSCG system needs to function.

We need to understand the Trust systems for CSCG:

- Who takes decisions and who is accountable for the decisions and the following action or inaction?
- How will we communicate these decisions and provide organisational intelligence to improve patient safety learning?
- How will we achieve the actions which flow from these decisions and meet the increasing CSCG agenda?

The description of Trust systems will then be followed by a brief synopsis of the processes within the CSCG model, for example complaints, incidents, etc. The description will be at a high and generic level as the core business for each Directorate varies in nature and thus so will the detail. However it is expected that the Directorate detail, if not already in place, will be worked through by the Operational Director and their teams facilitated by the Directorate Governance Coordinator when appointed.

Finally within this section a brief description of each of the new job roles within the CSCG system will be presented. Detailed job descriptions for new roles are available on request; those whose role will be essentially similar with the same banding, but whose lines of reporting will change, will be invited to participate in formulating revised job descriptions for their modified roles.

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What category each post falls into, new or modified will be detailed in section 4.

It should be noted that the banding for these posts are indicative bandings which are yet to be subject to desktop banding process.

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Three Core Components of CSCG - Structure

CORPORATE COORDINATION &OVERVIEW

Reporting to Chief Executive's Office:

1 wte Band 8C AD CSCG
1 wte Band 5 Governance Officer
1 wte Band 3 Governance admin Assistant
1 wte Band 7 (Temporary for 1 year) Governance Training Officer
Current central reporting team (Systems manager will report to Informatics Division)
Current Effectiveness and Evaluation team

OPERATIONAL Directors & their teams

Will be supported by a Directorate Governance team using both existing arrangements and complemented by proposed new arrangements

Existing Structure:
AMD's,
CD's,
AD's,
AD / HOS senior Directorate advisor for nursing, AHP and Social work
In reach nurse workforce, dev & training
In reach Social work governance, workforce dev & training

New Structure:
1 wte Band 8B governance coordinator reporting to Director
1 wte Band 5 governance officer (*1.6 wte in Acute services)
1 wte Band 3 governance admin assistant (*1.6 wte in Acute service)
Pro rata wte Band 7 nurse governance facilitator (previously practice support & governance lead)
1 wte AHP Directorate Lead (Operational and Governance lead)
****Acute services only**
1 wte Band 7 Patient Safety & Quality Manager (Encompass standards &Guidelines)
1 wte Band 6 Patient Safety & Quality Officer

Assurance

Support

PROFESSIONAL Executive Directors & their teams

Nursing:
2 wte Band 8C (current posts)
Education, training & Development team (current team)

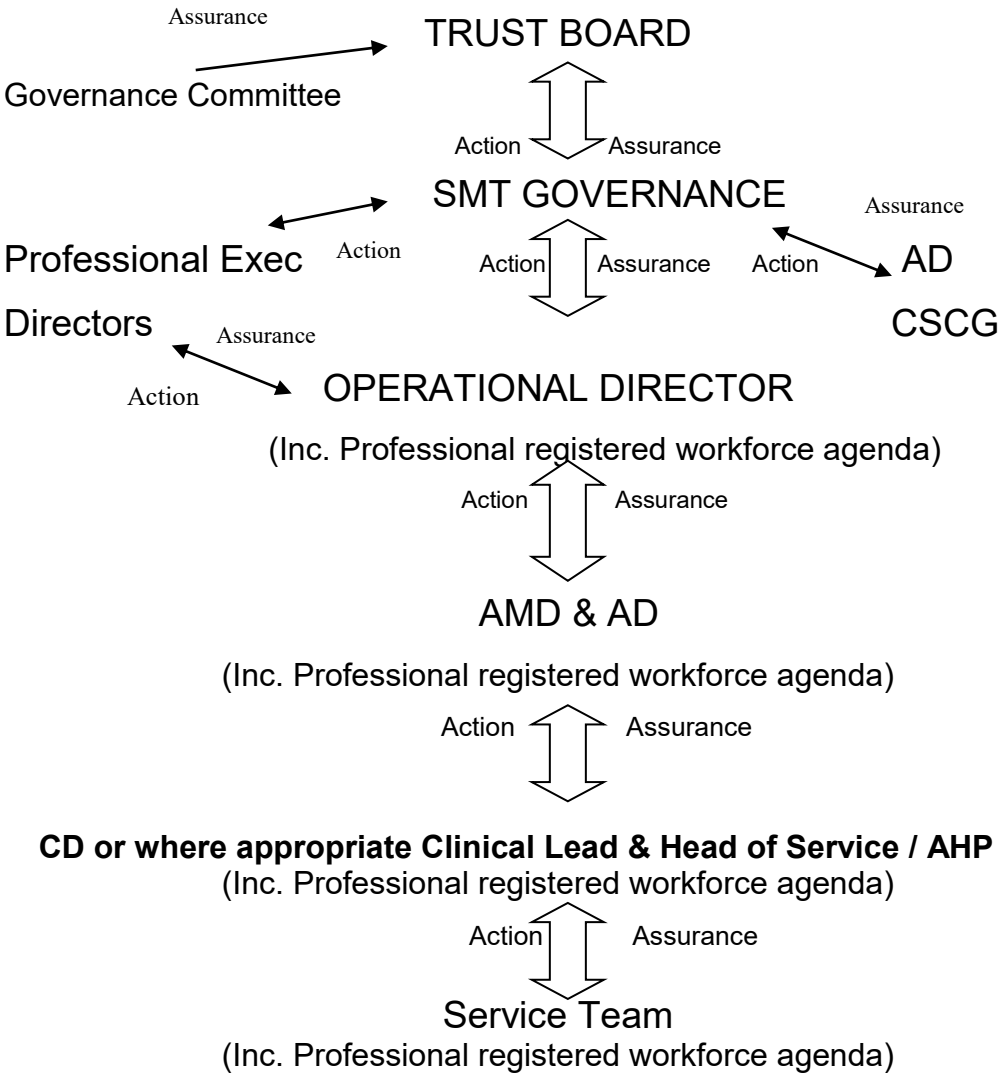
AHP:
1 wte Band 8C (current post)
1 wte Band 7 workforce development and training (new post, temporary for one year in the first instance)

Social Care:
1 wte Band 8C (Current post)
Governance, workforce development and training team (current team)

Medical:
8b Medical workforce (current post)
Band 7 (Current post)
Band 6 Patient Safety Initiatives Officer (current post)
Litigation team (current posts)

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SYSTEM FOR DECISION, ACTION & ACCOUNTABILITY



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Explanatory Notes:

- Each level in the diagram is both a decision making point and a point of accountability following a decision and action.

- SMT Governance is the central point for decision making in relation to the **organisational CSCG agenda.** They are guided, advised and obtain organisational intelligence from the Executive Directors, Operational Directors and their teams and the AD CSCG. The forum for this to take place is described in the next flow diagram on page 12. This should result in a clear, single corporate agenda for all aspects of CSCG, and an awareness of the CSCG workload across the Trust, preventing too many initiatives being worked on at any one time.

- The central point for decision making in relation to CSCG decisions involving procedure, resources or a change in practice is the Operational Director who will be advised by and communicate with SMT Governance, AD's and AMD'S and where appropriate Executive Directors.

- SMT Governance are accountable to Trust Board

- The Governance Committee provide independent assurance to Trust Board that SMT Governance is undertaking it's responsibilities in a thorough and acceptable way. The Executive Directors assist Governance Committee by providing independent assurance to the latter and Trust Board.

- Executive Directors assure and advise SMT Governance on workforce standards, training, education & development and provide exception alerts to SMT Governance.
- This facilitates decisions on the Professional registered workforce agenda to be agreed at SMT Governance before dissemination to the wider organisation

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- The Executive Director of Nursing will for the most part delegate to their Assistant Directors for governance and workforce standards, training, education & development. For the purposes of this document where Executive Director Nursing & Midwifery is used this is interchangeable with the AD positions in this office.

- The Executive Medical Director / Responsible Officer will have additional responsibilities which include litigation, medical appraisal, fitness to practice, research & development, emergency planning, infection control and lead for Healthcare Acquired Infection performance. They will also be the lead professional Director for information governance and the Trust representative on the Regional Patient Safety forum and for the performance monitoring and reporting of specific DHSSPS Patient Safety Initiatives. In discharging the latter role the Medical Director will agree monitoring arrangements for DHSSPS Patient Safety Initiatives with the appropriate Service Director.

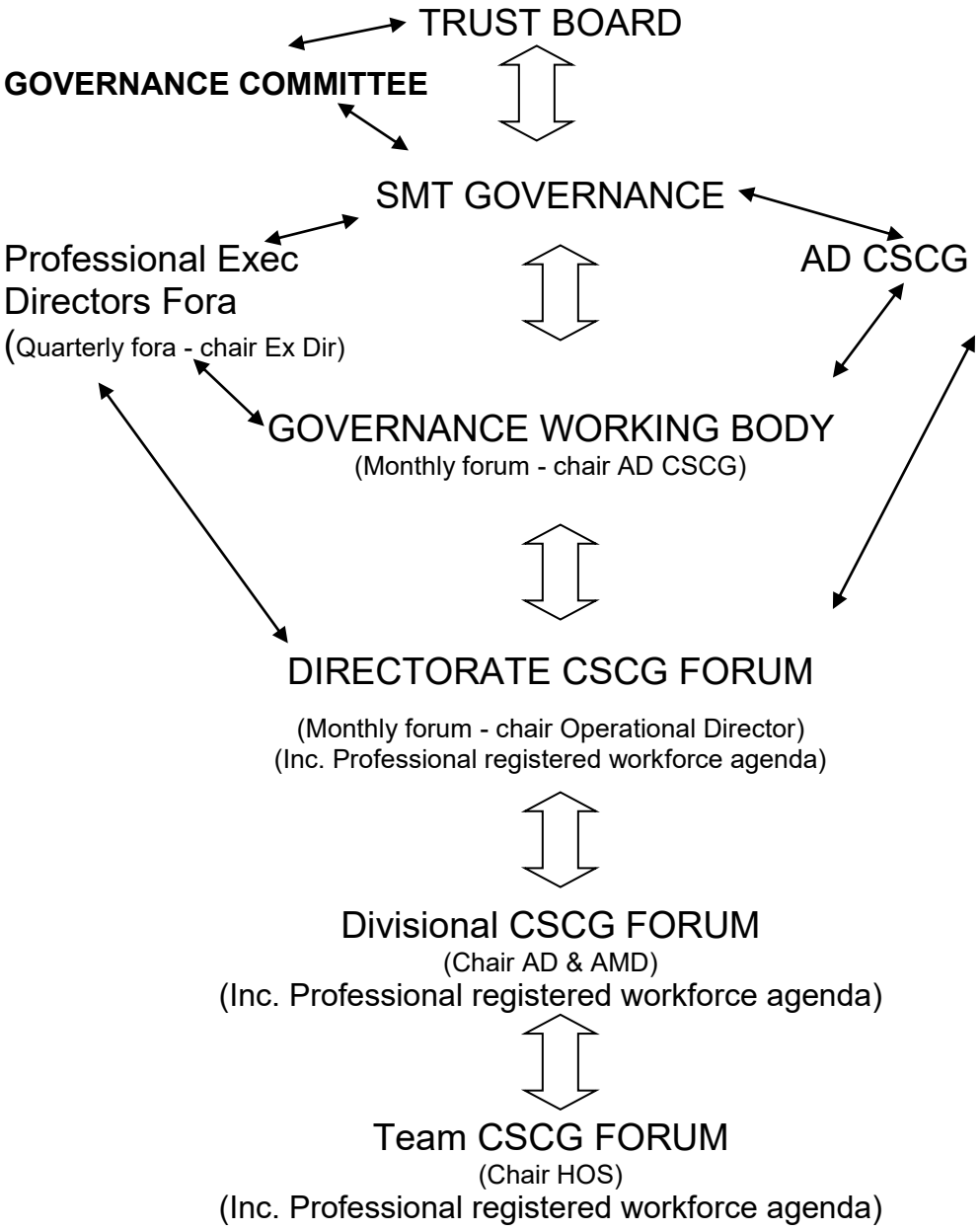
- Responsibility and accountability for patient safety and quality lies with the Operational Directors.

- Operational Directors provide assurance to Executive Directors on workforce standards, training, education & development. The Executive Directors will agree and assess the assurance information which should be provided and give SMT Governance an independent and considered view on the professional workforce.

- Operational Directors are responsible & accountable for all aspects of CSCG to SMT Governance and its chair the Chief Executive, and via this body through to Trust Board.
- The AMD & AD are responsible & accountable for all aspects of CSCG within their area to the Operational Director

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System for Communication & Organisational Connectivity (Intelligence Flows)



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Explanatory Notes:

- As previously illustrated the decision hub of SMT Governance will be informed by the Governance Working Body. This group chaired by the AD CSCG will be instrumental in proposing, forward planning, implementing and reviewing a practical and robust CSCG agenda to be endorsed by SMT Governance. This will provide SMT Governance with the capacity to focus on the strategic and operational direction of CSCG based on good intelligence and sound information and allow them to focus on critical issues, organisational risks and decisions on prioritisation of CSCG issues.

- The Governance working body will therefore have a Trust wide membership including Executive Directors or their representatives (Medical, Nursing & midwifery, AHP, Social work), AD's and AMD's, Directorate CSCG Coordinators, Pharmacy, Estates, Health & Safety, Human Resources, Litigation, Effectiveness & Evaluation and other co-opted members as required. All other CSCG committees, such as Drugs and Therapeutics will be represented at the working body and feed in their reports for assimilation to SMT Governance. It will meet monthly and have corporate priorities, plans and proposals, progress and outcomes endorsed by SMT Governance.

- This working group is central to the coordination and success of the CSCG agenda within the Trust and in order to facilitate membership, attendance and participation there will be a streamlining in the frequency and agenda of uni-professional fora held during a financial year. There will be one Nursing & Midwifery forum across the Trust, one social work & care forum, one AHP forum and one Medical forum focussed on workforce standards, training and development, each chaired by the respective Executive Director. These will be held quarterly for resolved professional advice on workforce issues which will be fed into the Governance working body and SMT Governance, information sharing,

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communication and debate. No other uni-professional fora will take place as the Governance Working Body and Directorate Governance Fora will now be responsible for, on a wider and more coordinated platform, implementing the agreed standards within the significant professional workforce agenda.

- Another essential decision hub is the Directorate Governance Forum chaired by the Operational Director. Again this monthly forum will be another key point for input from the Executive Director teams and will monitor progress and review outcomes of CSCG initiatives within the Directorate including implementation of the agreed workforce standards.

- The Executive Director's delegated representatives (usually the Band 8C for each profession) will attend the appropriate parts of this monthly forum. They will on behalf of the Executive Director provide expert advice and guidance as well as a performance management role in relation to seeking assurances on workforce standards and an acceptable level of compliance with quality and safety indicators.

- Within this forum the Executive representatives will discuss any aspects of poor or unacceptable levels of compliance with the Directorate and will by exception alert the corporate organisation if performance against indicators is unacceptable and irresolvable.

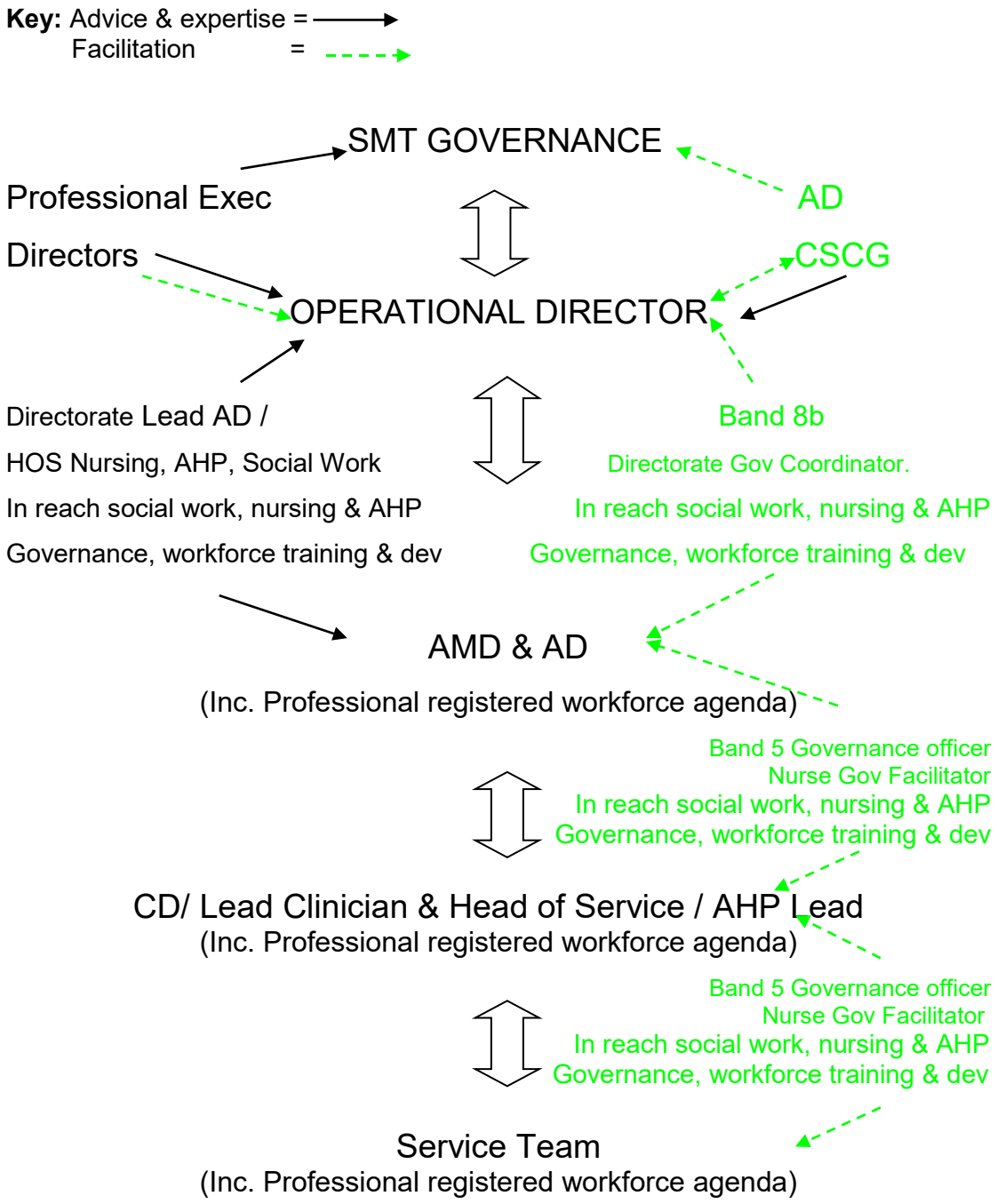
- It is essential that all decisions on issues of CSCG policy, procedure, resources and changes in practice are brought to the Governance Working Body for discussion and organisational learning and intelligence. They should also be escalated to SMT Governance for endorsement or a decision or as an alert and then be devolved to Directorate Governance fora for implementation and / or further action. Decisions taken outside these hubs or interaction at other levels of the organisation with teams or individuals should be avoided as this could lead to confusion of accountability, conflicting communication and non optimum accountability.

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- In the exceptional circumstance where a registered or non registered member of staff at any level within the organisation believes that an issue of CSCG is not being addressed at team, division, directorate or a corporate level they should highlight this in the first instance through the accountability and communication lines set out above. However if the highlighted issue is not being addressed and the reasons for this are either not communicated or not acceptable, staff are encouraged once all line management communication lines are exhausted to raise the issue to either the Executive Directors office or that of the Chief Executive through the AD CSCG. This exception reporting is a further safety mechanism within the organisation to ensure that all CSCG decisions and actions are taken as intended by the accountable officers involved, namely SMT Governance.

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SYSTEM FOR SUPPORTING THE CSCG AGENDA



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Explanatory Notes:

- As with communication, decision making and accountability, facilitation and expert advice by the right people at the right level of the organisation is key to the success of the CSCG agenda.

- SMT governance will be facilitated by the AD CSCG, who will provide intelligence, information and real time data from across the Trust and via the Governance Working Body.

- SMT Governance will also be provided with expert advice and receive compliance monitoring on professional workforce standards, education, training & development from Professional Executive Directors.

- Operational Directors will provide further Directorate information and assurance on compliance with CSCG standards to SMT Governance.

- Operational Directors will be supported in their role by the AD CSCG, their Band 8b CSCG Coordinator and in reach support from the Professional Executive Directors' offices. The Operational Director will also receive expert advice and guidance on uni - professional issues from their most senior staff within each profession – the AD/HOS/Lead for Nursing, AHP, Social Work and AMD's for Medicine, this is an existing role within each Directorate.

- The above assistance to the Operational Director and their team are advisory and facilitatory providing expert guidance and "another pair of hands" to assist with this large agenda. However each individual AD and AMD for each division / Directorate are responsible and accountable to the Operational Director for the delivery of the CSCG agenda within their specific service area, as in turn is the Operational Director to SMT Governance.

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PROCESSES TO SUPPORT THE CSCG AGENDA

These processes are essential components of the CSCG systems and should be viewed as individual parts of a larger patient and client safety and quality reporting process, which when combined, maps the journey through Trust services from the user perspective. This mapping should give the organisation a clear picture in relation to user experience and outcomes and identify when and where these outcomes are sub-optimal; some literature describes these measurable, sub-optimal outcomes as the 6 D's, death, disease, dysfunction, disability, dissatisfaction and dollars or the follow up to poor care. While these measure the less positive side of the service user's journey these are the outcomes we need to prevent whenever possible to protect staff and those who use our services. When fed into the CSCG systems the outcomes from the processes of complaints, incidents, effectiveness & evaluation, litigation etc should enable the organisation to predict where problems may arise, manage risk by making uncertainty visible and ensuring we have contingencies and controls to minimise these risks and ensure learning.

Participation by clinical teams in CSCG processes in which they have confidence is essential to build a safe organisation. It is clearly recognised that in an organisation of this size where we provide health and social care for those who need it most that there will inevitably be poor outcomes for a number of patients and clients. However where the poor outcome was not inevitable but preventable, this in itself only becomes a disaster when it is allowed to be repeated. That is why we need organisational processes that frontline staff will use to detect, analyse and respond to poor outcomes to prevent the likelihood of them being repeated. At all levels the organisation needs to identify the important problems and issues, analyse and respond to them in an appropriate and coordinated way.

The processes described below are dependent on the roll out of the web based management information system - DATIX, which will take place over the next year to eighteen months. Several of the processes will also require

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review and potential revision following phased implementation of the recommendation within the governance review.

Process 1: Complaints

- Complaint received by central reporting in AD CSCG office. Logged on system. Sent electronically to Directorate Governance coordinator.
- Governance coordinator screens and prioritises for Assistant Director (AD), Associate Medical Director (AMD) and Director attention or Head of service (HOS) and service team attention. Electronically transferred to AD / AMD/ Director or HOS /team.
- Directorate governance officer monitors complaint progress and ensures timeframes adhered to as laid out in the Trust Complaints policy. Provides assistance as required to service team
- Response agreed with service team, AD, AMD and Director, as appropriate, by Directorate Governance Coordinator before being sent to complainant - eventually this process will be managed by the Directorate governance officer and rely less on input from the Governance coordinator
- It is envisaged that this system will be improved by the potential roll out of the web based datix module for complaints which will be on staff desktops. The roll out of the information management system will also significantly improve our ability to track trends of complaints and share learning at a team, division, directorate and corporate level – a role taken on by the Directorate governance coordinators and the AD CSCG. Shared learning will take place via the Governance Working Body and recommendations for change will be agreed and prioritised by SMT Governance

NB: Ombudsman issues will be dealt with in a similar format but will have input from the AD CSCG to ensure organisational learning. Chief Executive will sign off these responses.

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Process 2: Incidents

This area of work will change significantly from the current process with the piloting and roll out of web based datix for incident management during the next 6- 9 months. Described below is a vision of what the process will be when the web based system is in place.

- Incident occurs within service team – reported by a member of the team via the web based system on their desktop.
- The reporting format will have been designed by the team and the incident will then be electronically alerted to the team line management
- Directorate Governance coordinator and service AD'S / AMD's /HOS will have an agreed process for service teams to action and deal with incidents in real time. An example of how this is achieved currently within one team can be found in Appendix 4. The detail of this may vary within each Division and Directorate – particularly the who and the how, however the principles of senior clinical involvement and a practical, workable mechanism to ensure learning is shared within the teams / division / directorate must be a key element of the process that is clearly visible.
- Incidents will then be reviewed on weekly real time reports by teams, Divisions, Directorates and at a corporate level, as will the recorded action and learning by the teams.
- Incidents that have not been actioned, closed and learning taken from them will be evident at team, Divisional, Directorate level and a corporate level by the AD CSCG
- Trends, learning and failure to effectively address incidents will also be identified and actioned by the Directorate Governance coordinator through the Directorate CSCG forum and the AD CSCG. These will be shared within the Governance working body and analysed as to whether escalation of learning is required to SMT Governance.

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Process 3: Patient Safety & Quality (inc. Standards & Guidelines):

The Trust currently receives a significant volume of standards and guidelines and key performance indicators from various professional and patient safety bodies including NPSA, NICE, NCEPOD, RQIA, Chief Nursing Officer, the Chief Medical Officer and the Departmental Director of Safety, Quality and Standards. The following describes the process of how these publications will be dealt with.

- The office of the Chief Executive will be the central receptacle for these standards, guidelines and recommendations. Any such communication received at any other point within the Trust should be redirected to this central point.
- They will be logged on a database within the office of the AD CSCG and early distribution will take place to relevant Directors for information and consideration prior to a work plan being developed by the Governance working body.
- The AD CSCG will table the publications at the Governance working body meeting and a relevant implementation team will be identified within each Directorate including any assistance required from professional, operational and governance leads.
- A timetable and implementation plan will be agreed by this team and reports on progress and constraints and monitoring of progress will be via the Governance working body.
- Executive Directors requiring monitoring progress on any professional specific standards and guidance will also receive progress reports and updates on assurance from Directorates via their AD representatives on the Governance working body.
- The Medical Director will receive information on the specific Departmental Patient Safety Initiatives in the same way via his Band 6 representative.
- Each Directorate can then monitor the number of ongoing implementation plans and feasibility of implementing standards and

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guidelines through their Directorate Governance coordinator who sits on the Governance working body

- Due to the highest percentage of standards, guidelines and recommendations requiring implementation being within the Acute Services Directorate, this service will have 1 wte Band 7 Patient Safety and Quality manager and 1 wte Band 6 Patient Safety and Quality officer
- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment.
- They will also maintain the ongoing programme of undertaking the ISO quality standard for equipment management in order to support the maintenance and safe use of equipment.
- The Patient Safety and Quality Manager will also chair a small sub committee of the Governance Working Body which includes estate services, representation from the older people and primary care Directorate and Acute services together with Health & Safety representation. This will ensure the ability to address any issues arising from Medical Devices on a Trust wide basis and should include the procurement of new equipment from a user and continuity perspective.

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Process 4: Risk Management

This process will be taken forward by the Directorate Governance Coordinators and service teams. Again it is envisaged that during the phased implementation of the web based Datix management information system this process will become less labour intensive. Further work is required within this area to ensure that there is an organisational understanding of the principles behind risk management and a clear process for the management of identified risk. Risk registers should not be a long list of concerns; it is a formal record of potential / possible / probable dangers which could result in loss, harm or failure and detail how this risk

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is being managed. The organisation at every level must have a mechanism for detection, prevention and contingency for risks and have a resolved position at each level in the Trust as to acceptable levels of risk which can be borne and those which cannot.

The improvement of the organisational understanding of risk management at a team, division, directorate and corporate level will be a follow up project for the AD CSCG, Directors, service teams and Directorate Governance Coordinators when the new structures are in place. Training to support effective organisational understanding and operation of risk management systems will be led by the Governance Training Officer within the central coordinating function.

Process 5: Registered & Unregistered Workforce Standards, Quality, Training & Education

- CSCG and workforce training, education and development are inextricably linked, the latter flowing from the need to ensure patient and client safety and quality care and the systems and processes of the organisational model of CSCG indicating issues of safety and quality. Therefore to ensure these links are made and that a coordinated approach is taken both across Directorates and at a corporate level and that the profile of education, training and development is raised and is targeted at supporting patient and client safety and quality care, there is a need to describe how this function will be delivered and where the lines of communication and accountability lie. This has been done in diagrammatic form earlier within the paper but will be repeated for clarity.
- The offices of the current Executive Directors will continue to be responsible for setting, advising on and monitoring standards of safety, quality, training and education of the registered workforce including Medicine, Nursing, AHP and Social work. They will also independently assess and provide assurance on the levels of compliance with these standards to SMT Governance, Governance

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Committee and Trust Board, while providing a corporate alert when compliance with standards is at an unacceptable level.

- However as the Executive function is neither a line management nor an operational role, it cannot be held accountable for delivering the actions required to implement agreed workforce standards and quality and safety of care.

- This accountability, for implementing agreed workforce standards, clearly lies with the Operational Director charged with delivering this service, who must provide assurance to the Executive function that action is taking place to ensure a workforce of an acceptable standard and safe and high quality care is delivered.

- The Operational Directors will achieve this through their Directorate Governance team. The Accountability chain for implementing the required standards and for highlighting training, education and development needs flows up from Heads of Service, AHP leads and Clinical Directors to Assistant Directors and Associate Medical Directors to the Operational Director who assures the appropriate Executive Director and is accountable to the Chief Executive. This Operational team will be supported and facilitated internally by the Directorate Governance Coordinator, the Nurse Governance Facilitators, the Lead AD Nursing Advisor, the AHP lead, lead for Social Work and AMD's. They will have in reach support from the Social Work governance, workforce development and training team, Nursing and Midwifery education, training and development team, the AHP governance and workforce development and training support and the medical workforce team all of whom are within the relevant Executive Director's office.

- The vehicle for this to take place should be the Directorate, divisional and service team governance meetings, with final sign off

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of any issues pertaining to workforce standards, training, education and development being achieved at the Directorate Governance meeting. This ensures that there is a coordinated approach to this issue by Directorate, due consideration given to Directorate workloads and pressures and that those who will be held accountable for implementation – the Operational Directorate - are engaged in the process. Those described above who facilitate, advise and monitor workforce issues should therefore attend the Directorate Governance meeting to provide expert advice and to seek assurances on compliance with agreed standards.

- In relation to the non registered workforce, to ensure that standards, quality and opportunities for workforce training and development are afforded to them, each staff group will have a lead Director appointed to implement this agenda.

- To ensure a corporate, value for money approach to workforce training, development and education the SMT has recommended that the Director of Human Resources chairs a Trust wide forum to enable a uniform approach to workforce development and training for both registered and unregistered staff. This forum will be fed by the collaborative working between Directorate and Executive functions described above and will have Directorate and Executive representation.

Process 6: Clinical indicators and Audit

- Executive Directors will provide expert advice and guidance on the organisational and service level quality indicators that will provide evidence of the safety and quality of care of care systems and the competence of the professional workforce within the Trust.
- The responsibility for progress and achievement of acceptable performance against these indicators rests with the Operational Directors and their teams. Again the Directorate Governance teams will support the service teams with this process.

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- Directorate level audit, as agreed by SMT, will be undertaken and reviewed by service teams. The Executive Directors will also review these audits to ensure an acceptable level of compliance with quality and safety indicators and will alert the corporate organisation if performance against the indicators is unacceptable.

Process 7: Effectiveness and Evaluation

- Effectiveness and Evaluation team will in the main undertake audit of quality and safety indicators which are of a more corporate nature and provide a sound basis for a patient and client safety learning system.
- This programme of work will be decided by the SMT Governance, with advice and input from the Governance Working Body.
- Although having a corporate function and being centrally managed, the E&E team will continue to provide expert advice to Directorate teams in methodologies etc.

Process 8: Litigation

- Increased collaborative working between Operational Directors, their AMD's and AD's will be facilitated by the Medical Director and the litigation team.
- The Medical Director will bring forward a recommendation on how this will be achieved and through what forum.
- The Director of HR will act as an expert advisor on all non medical litigation, and will seek professional expert advice in relation to Social Work, AHP, and nursing when appropriate.
- The Directorate Governance coordinator will act as a conjugate within this system having a collaborative working relationship with the Litigation team.

Process 9: Morbidity and Mortality

- A review of current processes for the above has commenced with the purpose of ensuring integration and accountability structures within the wider CSCG systems in the Trust.

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- This review will complete by the end of December and its recommendations will be integrated into the implementation plan of the CSCG Review.

Process 10: Managing Poor Professional Conduct and Performance

- The processes for the above have been the subject of revision as part of the Review of Governance. The Trust processes are attached in appendix 3
- It is evident from the processes that those involved are also those who can action change and effect patient and client safety. These processes should be reported on a regular basis at Directorate level and learning issues raised through the Governance Working Body

Supporting Infrastructure - Web Based Datix

As discussed previously the above processes will be significantly enhanced and supported by the roll out across the Trust of the Web based information management system Datix. This will mean that all clinical teams will have on their desktops modules for incident management, complaints, risk management and standards and guidelines management.

Following roll out and training staff will be able to for example log incidents in real time, line managers and others can be alerted to incidents and there is a real time view of how these are being actioned and who is taking this forward. This should result in staff getting real time feedback on incidents reported and actually seeing changes to practice being made. It will also enable everyone to have access to much improved data on how safe our services are and how we are improving them.

This is an exciting new development which will give service teams the opportunity to tailor a system to meet their requirements and get real time information from it on issues of CSCG. Roll out commences in January 2011 with two pilot sites which are Delivery Suite, CAH and Bluestone Unit within Mental Health and Disability services.

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New and Modified Job Roles

Function: Corporate Coordination and Overview

WTE Band 8C AD CSCG: (Modified role)

- This role will provide the SMT Governance with a Trust wide overview on all the CSCG systems and processes and their outputs. They will provide well analysed information to support decision making, prioritisation and awareness re exceptions and trends, thus enabling improved information to support both the SMT Governance and provide assurance to Governance Committee.
- The post holder will provide an early warning system from the process outcomes and highlight potential Directorate and Trust risks and will monitor trends.
- They will chair the Governance working body and ensure standards, guidance; alerts etc are planned, implemented and reviewed.
- They will ensure that corporate strategic intent is interpreted correctly at operational level and that it can be implemented. They will provide assistance to individual Directorates and their Directorate Governance team as required.
- They will continue to implement the Governance review findings in a phased approach and assist the Informatics Directorate with the information system roll out.
- They will manage the Serious Adverse Incident (SAI) process at a corporate level and the subsequent RCA reports required at a regional level
- Within the Trust this post holder will when appointed oversee a review of the internal use of RCA's and produce a policy and procedure detailing incident review and learning
- This post will report to the Chief Executive

WTE Band 5 Governance Officer (New Role)

- Manage staff and processes in relation to Central Reporting.

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- Produce reports on a trust wide basis for all CSCG processes together with an early warning alert for exceptions to the AD CSCG.
- Manage the administration of the processes and systems relating to CSCG within this corporate function including the Governance working body, complaints, SAI reporting and subsequent regional RCA's together with the receipt and monitoring of standards and guidelines, RQIA reports etc
- This post reports to the AD CSCG

WTE Band 7 (Temporary for 1 year) Governance Training Officer (New Role)

- To embed the new systems and processes within the organisation by the provision of targeted training in incident and complaint management, resolution and learning.
- Specifically in the area of risk management to provide targeted training in respect of risk, recording, management and provision of contingencies.
- To work with all affected groups of staff to assist them in identifying issues or constraints within the processes and systems and to enable the successful adoption of the new model of CSCG.
- This post reports to the AD CSCG

WTE Band 3 Governance Admin Assistant (Modified role)

- This post will also exist in Operational Directorates with the same role, it currently exists within the Medical Directorate and would be similar in nature within the new structure
- To provide general administration to both the Corporate and Directorate CSCG offices.
- This post reports to the Band 5 Governance Officer

Function: Operational Directorate Governance Team

WTE Band 8B Directorate Governance Coordinator: (New role)

- On behalf of the Service Director, to take the lead within the Directorate

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in providing assurance to the organisation that both the operational and professional aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely action, risk management, assurance and alerts to both the Service Director and the organisation.

- Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and ensure learning has resulted in changes in practice.
- Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client safety and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely manner.
- This post reports to the Service Director

WTE Band 5 Governance Officer: (Modified role)

- This role will support the Band 8B and will line manage the Governance Admin Assistant.
- Specifically the tracking, compilation and administration of the complaints process will be undertaken for the Directorate by this post holder, under the supervision of the Band 8b.
- They will provide support to the Directorate teams with respect to identifying reports, trends and alerts and will monitor follow up action
- They will provide project assistance when required to the Directorate in relation to CSCG initiatives that are being undertaken
- They will liaise with the corporate CSCG office to ensure timely responses and information flows.
- This post will report to the Directorate Governance Coordinator.

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WTE Band 8b AHP Directorate Lead (Modified role)

- This post will be responsible and accountable for both the operational and professional management of all AHP's within the Directorate, with the exception of those who are already operationally line managed as part of an integrated team. Where this is the case the AHP lead will be responsible for the professional standard of those AHP's within that Directorate who are part of an integrated team. This type of post currently exists within the Acute Directorate.
- The post holder will liaise closely with senior staff at Band 8a and below within each profession in their Directorate. They will recognise and continue to utilise the experience and expertise of team leaders in uni – professional services.
- The AHP lead will also liaise closely and receive expert advice and guidance from the AD AHP Governance and workforce Development, training and education within the office of the Executive Director and should also seek advice and guidance as required from the most senior Trust employee in each individual profession.
- To assist with the provision of expertise and advice the most senior staff in each of the 7 AHP professions will meet with AHP leads via the AHP forum which will be chaired quarterly by the Executive Director.
- This post will report to a nominated AD within each Directorate.

WTE Band 7 Nurse Governance Facilitator (Modified role)

- This role, currently the practice support and governance team, will report to the Band 8b Directorate Governance Coordinator.
- They will support the service teams in the delivery of the significant nursing governance agenda which is inextricably linked to the service governance agenda.
- The resource will be provided to Directorates on a pro rata nursing wte basis
- This current group of staff will continue to receive supervision from the Band 8c AD for Nursing Governance.

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Function: Operational Directorate Governance Team (Acute Services Only)
WTE Band 7 Patient Safety and Quality Manager and Band 6 Patient Safety and Quality Officer (Encompassing standards & guidelines)

- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment. They will project manage and monitor these functions within the Acute Directorate
- They will also maintain the ongoing programme of undertaking the ISO quality standard for equipment management in order to support the maintenance and safe use of equipment.
- The Band 7 will be responsible for the Band 6 and will report to the Directorate Governance Coordinator.

Function: Executive Director Support (AHP & Medical are the Executive teams receiving new support)
WTE Band 7 Workforce Development, training and Education Officer AHP (new post temporary for 1 year)

- This post will assist the AD AHP Governance, workforce development, education and training. The post remit will be focused on education, training and development and will have a similar role to the equivalent team in within nurse education.
- This post will be available for 1 year in the first instance, after which the benefits of the role will be reassessed.
- This post will report to the AD AHP Governance and workforce development, education and training.

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Section 4:

Achieving the New Organisational Structures

Following the consultation period the implementation of the final organisational structures will be undertaken in accordance with the principles and protocols of the Trust's agreed *Management of Change Framework.*

At this point staff directly affected will have opportunity for a personal meeting to discuss individual circumstances and requirements. Staff wherever possible will be offered a suitable alternative employment opportunity and where it is not possible to do so, immediately affected staff will be placed on the Redeployment Register so that any suitable posts throughout the Trust will be brought to their attention before it is advertised more widely. This meeting will be followed up in writing.

Under the terms of it's agreed "Traceability Scheme" the Trust will consider applications for Voluntary Redundancy and Voluntary Early Retirement on a "without prejudice" basis.

Phasing:

The impact that the roll out of the new web based management information system (Datix) will have on the recommended CSCG systems, processes and proposed structures is in part an unknown. It is therefore proposed that while the structure as is proposed on page 10 of this document will be phase 1 of the implementation of the Review of CSCG, following the information system rollout over the next one to two years there will be a need to re- examine areas of the CSCG system administration in order to determine their future structure. However this can only be done following the completion of phase 1 and when the organisation has a clear understanding of the new embedded systems and processes and the impact of information technology.

Phase 1:

As described earlier a number of CSCG posts within the organisation will remain the same, another set of posts will have a similar job role with minor modifications to accommodate different reporting structures, while there will

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be a third group of posts which are new and will therefore be available for open competition.

Obviously the exciting development of creating new posts available for open competition within the Trust is coupled with the fact that as a result some current posts no longer exist within the new structure. The Trust recognises the work that staff in these posts have undertaken since the inception of the new organisation in the field of CSCG during a difficult time of merger; in the intervening period much has been learnt with respect to what makes a successful CSCG system and so with the benefit of recent National reviews the Trust must move forward and implement a system designed for the current and future climate of patient and client safety and quality.

CURRENT POSTS WHICH REMAIN UNCHANGED:

Professional Executive Directors & their teams
Nursing:
2 wte Band 8C
Education, training & Development team

AHP:
1 wte Band 8C

Social Care:
1 wte Band 8C
Governance, workforce development and training team

Medical Workforce:
1 wte Band 8B
Band 7
Band 6
Litigation team

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Explanatory Note:

- The current Practice Support & Governance Team for nursing (Band 7's) will be realigned to Service Directorates.
- The Band 8C AHP Governance will have an additional new post for 1 year in the first instance – AHP workforce development, education and training officer, Band 7.
- These changes will be summarised overleaf

CURRENT POSTS TO BE REALIGNED

To Service Directorates:

Band 7 Nurse Governance Facilitators (current Practice Support & Governance Team for nursing).

Band 5 Governance Officers (current governance support administrators within the Medical Directorate)

Band 3 Governance admin support (currently governance administrators within the Medical Directorate)

Band 8B AHP Leads (currently AHP HOS)

To Corporate Office of the Chief Executive:

Current Central Reporting Team

Please note the current systems manager will be realigned to the Informatics Division within the Planning and Performance Directorate

Current Effectiveness and Evaluation team

Explanatory Notes:

- It should be recognised that with any realignment there will be a modification of roles and responsibilities. It is intended that for those involved it should be minimal and modifications to job descriptors will be done in collaboration with the post holders.
- The Band 5 and band 3 realignment from the Medical Directorate will not be sufficient to meet the whole time equivalency recommended in the review; therefore there would be open competition for the additional posts within the Trust.

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- It is recognised that the role of AHP lead is a distinct modification of the current role of AHP HOS. It is intended that all the current HOS will be widely consulted with and that the job description for the role and which Directorate individuals will be reporting to will be worked on collaboratively with the HOS as a staff group.

NEW POSTS FOR OPEN COMPETITION WITHIN THE TRUST

Corporate Office of the Chief Executive:

Band 8C AD CSCG

Band 5 Governance Officer

Band 3 Governance Admin Assistant (additionality)

Band 7 (1 year) Governance Training Officer

Service Directorates:

Band 8B Governance Coordinator (4 posts)

Additional Band 5 Governance Officer (balance of those that currently exist in the Medical Directorate)

Additional Band 3 Governance admin assistant (balance of those that currently exist in the Medical Directorate)

Acute Services only:

Band 7 Patient Safety and Quality Manager (Encompass standards & Guidelines)

Executive Director Teams:

AHP: Band 7 Workforce development, education and training officer (1 year)

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SECTION 5: Equality Screening

The proposed organisational structures for Clinical &Social Care Governance (CSCG) emulating from the Review of CSCG within the SHSCT " A System of Trust" has been screened in line with the Trust's Guidance on Equality and Human Rights Screening. The outcome of the screening exercise has indicated that the proposed structures are not likely to have significant/major implications for equality of opportunity and therefore will not be subject to a full Equality Impact Assessment. The structures were considered not to have an impact on human rights of staff. A copy of the Screening Template is available on request from the Equality Assurance Unit, Hill Building, St Luke's Hospital Site, Armagh.

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SECTION 6: The Consultation Process

The purpose of the consultation paper is to seek your views on the proposed restructuring and in particular the following questions:

- Do you think that any aspects of an effective CSCG system and/or its processes are missing

- Do you think that any aspects of an effective CSCG system and/or its processes are unclear within the model described?

- Are the new and modified roles as described within the CSCG model sufficiently clear?

- The role of the Directorate Governance Coordinator is key in achieving clinical and operational management engagement in the model and therefore critical to its success. Do you think post holders should have a clinical background?

- Are there any other barriers to achieving the necessary clinical engagement and ownership required to make the CSCG model work effectively?

- Do you have any other comments on the consultation document?

To this end, the Trust intends to consult as widely as possible with those directly affected and those with a vested interest. The consultation period will commence on 8th December and will conclude on 22nd December, following which the final structures will be determined.

Staff who wish to discuss the proposed structures with the Chief Executive and Director of Human Resources & Organisational Development may do so

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by contacting the HR office overleaf and arrangements will be made to meet with individuals or teams during the consultation period.

Staff are encouraged to participate in this consultation exercise and express their individual and/or collective views on the proposed structures. Staff can participate by sending their comments by writing/e-mailing to Catherine Irwin, Employee Engagement & Relations Department, Human Resources & Organisational Development Directorate, at the address below:-

Mrs Catherine Irwin
Employee Engagement & Relations Department
Hill Building
St Luke's Hospital Site
Armagh
Tel: Personal Information redacted by USI

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Appendix 1 Review of CSCG

Please refer to separate attachment with this email

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Appendix 2 - Terms of Reference for Review of CSCG

Southern Health
and Social Care Trust

Chair
Anne Balmer LLB BL

Chief Executive
Colm Donaghy

Our ref: MMcAl/ew

11 March 2010

To: Directors

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE

I refer to the recent review of assurance mechanisms for clinical and social care governance and the recommendations approved by Senior Management Team which included the establishment of the post of Head of Governance and a virtual Clinical and Social Care Governance Team.

An internal recruitment process for the Head of Governance post was recently undertaken however, while the post was offered, we have been unable to complete the recruitment process. The post will now be externally advertised.

Through engagement and consultation with staff, a number of issues have been raised regarding the robustness of our current governance operational and assurance systems, processes, capacity and capability. It is critical that these issues are explored and addressed, and should not be delayed pending appointment to the Head of Governance post.

I have therefore commissioned an urgent review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information available to provide assurance on the safety and quality of our care.

Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI www.southerntrust.hscni.net

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This review will focus on the effectiveness of current mechanisms to ensure that safety and quality indicators are being properly captured, identified and addressed, and will provide advice to SMT Governance on any actions required to improve the Trust's governance arrangements.

The Review will be carried out by Mrs Deborah Burns and will commence on 1 April for a three month period, reporting to myself as Chair of SMT Governance.

I would be grateful if you would share this letter with your Assistant Directors and Associate Medical Directors for circulation, as I am aware of the high degree of interest in this issue.

Yours sincerely

Personal Information redacted by the USI

MAIREAD McALINDEN
ACTING CHIEF EXECUTIVE

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TERMS OF REFERENCE

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

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Review Terms of Reference

The Trust has agreed to appoint a project manager on an interim basis for three months.

The aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms in relation to:

- The appropriate and timely identification of risks in relation to the safety and quality of clinical and social care.
- The use of adverse incident reporting, 'near misses', risk assessments, complaints and other information sources to inform the identification of such risks.
- The effectiveness of current systems, processes, capabilities and capacity in providing effective management of such risks.
- Systems to ensure that lessons are learned from these internal processes and embedded throughout the Trust.
- Systems to draw and evaluate learning from elsewhere and use this information to assess and where necessary improve safety and quality of care.
- Clinical engagement and involvement in clinical and social care governance systems, processes and assurance mechanisms.
- Processes for ensuring the implementation of standards and guidelines.
- Support to and within Directorates to effectively implement the above.
- The selection, capture, measurement and reporting of safety and quality indicators and information to provide robust assurance to SMT Governance, Governance Committee and Trust Board on the safety and quality of Trust services.

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- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for clinical and social care governance.

The Project Manager will undertake a process of in-depth engagement with key stakeholders to ensure this assessment of effectiveness is robust, and to ensure ownership for any associated recommendations for improvement. Part of this engagement process will be the establishment of the 'Virtual Clinical and Social Care Governance Team' as to act in support of the Project Manager and as a key stakeholder group.

This assessment and engagement process will inform the Project Manager's recommendations to SMT Governance in relation to current and planned future clinical and social care governance arrangements, and will complement and integrate with the development of an action plan which ensures the findings and learning from the report into Mid-Staffordshire NHS Foundation Trust are implemented within the Southern Trust.

This assessment, recommendations and action plan will be presented to SMT Governance by the end of June, with updates on progress being provided on a monthly basis for the duration of the Review.

The project manager will report to the Chief Executive for the duration of the project.

March 2010

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Appendix 3: Processes for managing poor professional performance and conduct

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

* If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

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Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

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Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:

- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:

- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Received from Marsad McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Clinical Performance Hearings

During the hearing:

- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce

Decision of the panel may be:

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision.
The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the

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Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

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Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Agreement 6: – Managing poor professional performance - Nurse, AHP, SW. Ref – Trust Disciplinary Procedure

Informal info

Incidents

Complaints

Risk register

Litigation

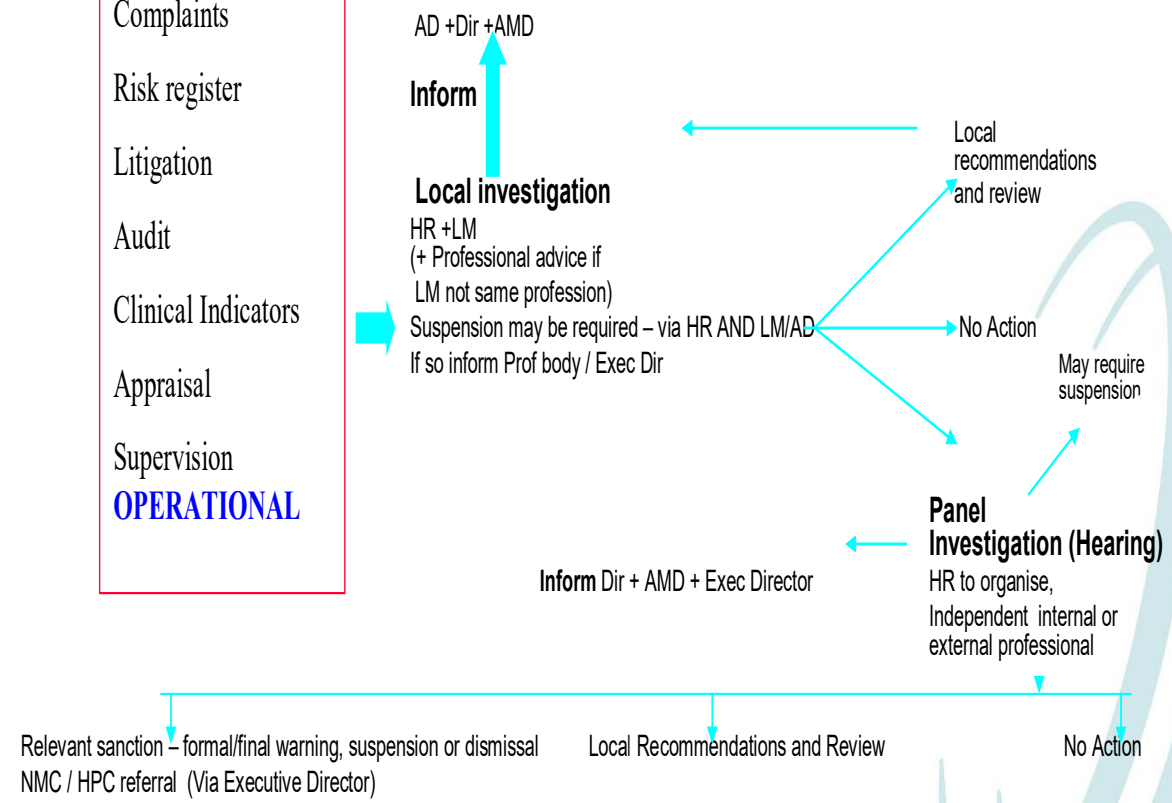
Audit

Clinical Indicators

Appraisal

Supervision

OPERATIONAL

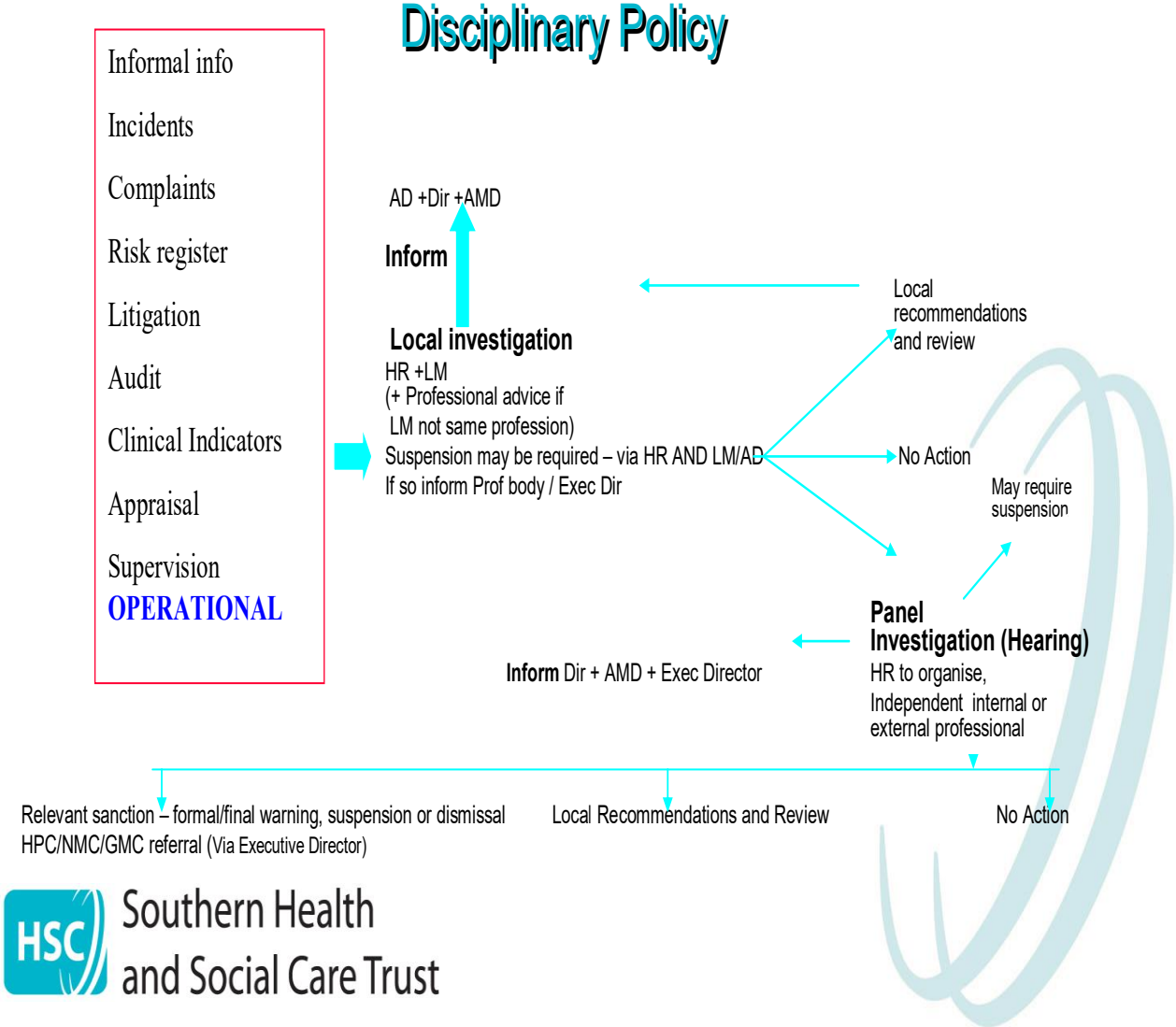


Southern Health and Social Care Trust

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Agreement 8: Managing poor conduct – all employees.

Ref – Trust Working Well Together Policy and Trust Disciplinary Policy

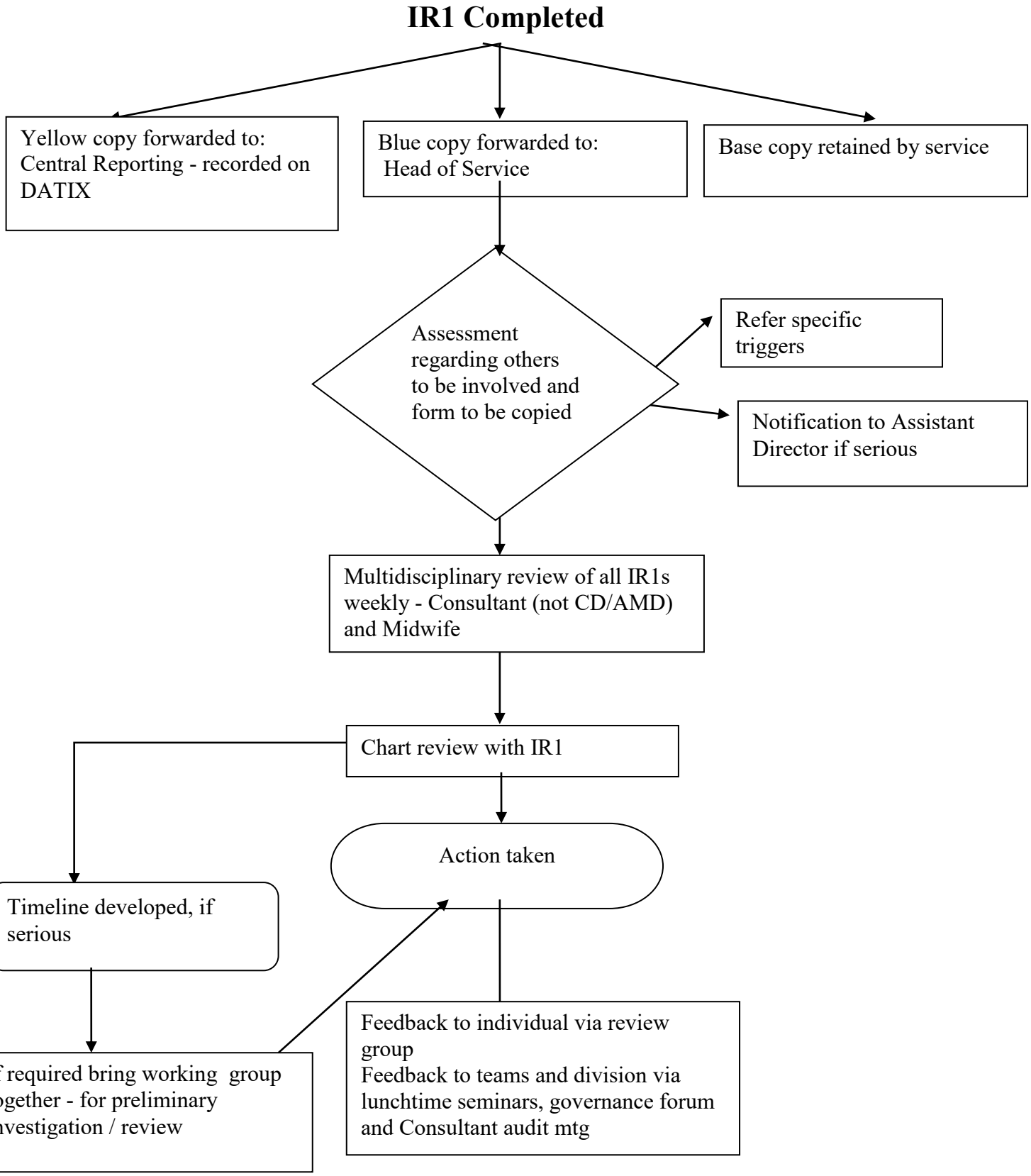


HSC Southern Health and Social Care Trust

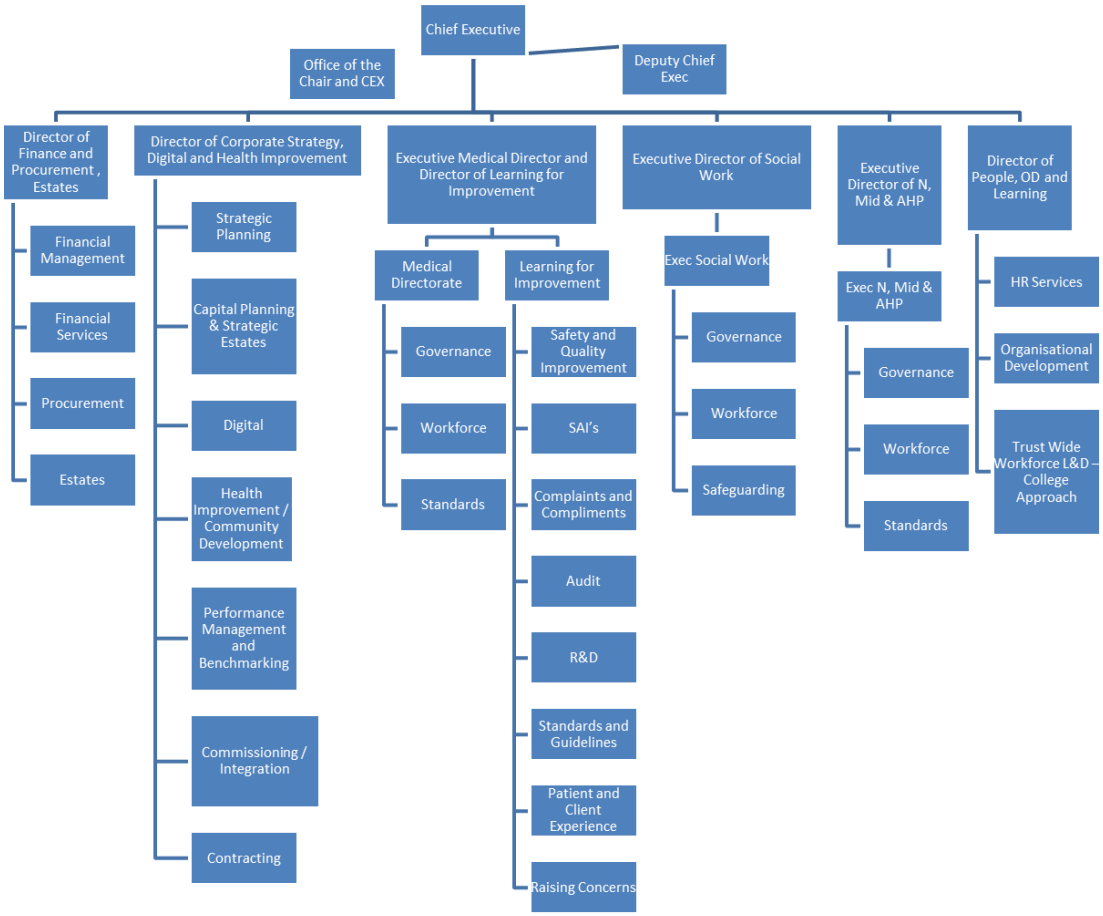
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Appendix 4 Example of - Acute Service Incident Management Process

Integrated Maternity and Women's Health - Model



Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.



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

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

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

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

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Director of Acute Services	Operationally and managerially responsible for the delivery of acute services
Director of Children's and Young Peoples Services	Operationally and managerially responsible for the delivery of children's and young people's services
Director of Mental Health and Learning Disability Services	Operationally and managerially responsible for the delivery of mental health and learning disability services
Director of Performance and Reform	Corporate responsibility for supporting and challenging all directorates to improve performance.
Director of Human Resources and Organisational Development	Corporate responsibility for HR systems to enable service delivery

This should include details of who has prime responsibility to patients and staff in those areas and how all the different roles work together. *Your answer should also cover how clinical governance is organised at both management and service level.*

Clinical Governance is currently managed at directorate level with each director providing assurance on their own portfolio. The Trust operates a corporate clinical governance office which supports the coordination of clinical governance activities, for example being the central point for the receipt of complaints, processing SAI notifications and reporting of Trust-wide statistics. Over the last 18 months I have positioned the organisation to adapt a more centrally manged model which will eventually see the central oversight of clinical governance via a directorate business partner arrangement. Appendix 16 outlines the agreed new model. My reason for wanting this model is well documented in previous questions (in particular, my answer to question 22). The previous system was dispersed across directorates with a lack of a corporate governance oversight. This new model aligns with the structural changes through the creation of a directorate for learning and improvement.

As referenced in question 44 and detailed throughout appendix 42 the lead role for patient safety and governance is dispersed at a number of levels. At an individual level the specific professional has the responsibility for the quality of care they deliver. However as can be seen from appendix 44 each directorate, and teams within it, play a specific role to monitor, challenge and improve. Ultimately safe care can only be delivered by the appropriate team being operationally accountable to the team manager whilst remaining professionally accountable to the professional lead (e.g., Medical Director) for their practice.

Q44	**How are you assured that the clinical risks, once identified, are mitigated sufficiently and appropriate assurance is provided? Do you consider that there are gaps in assurance as to how clinical risk is managed at service level? Overall, are you assured that clinical risk is being managed at the right level in the Trust, and that assurance is**
Response	*How are you assured that the clinical risks, once identified, are mitigated sufficiently and appropriate assurance is provided?* Key to my assurance is the management of the risk register process. In accordance with the 2020/21 Annual Internal Audit Plan, BSO Internal Audit (which is independent of the Southern Trust) carried out an audit of Risk Management during September 2020.(all audit outcomes are presented in question 53). The last Internal Audit of this topic was performed during February 2020 when Satisfactory assurance was provided in relation to the Management of Corporate Risks and the management of risk within the Performance and Reform and the Finance, Procurement and Estates Directorates.

Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

PEER REVIEW VISIT REPORT
(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2015
Peer Review Visit Date	16th June 2015

Compliance

	Self Assessment	Peer Review
UROLOGY LOCAL MDT MEASURES	70.0% (14/20)	35.0% (7/20)

Zonal Statement

Completed By	Clare Langslow
Job Title	Quality Manager
Date Completed	18 June 2015
Agreed By (Clinical Lead/Quality Director)	Richard McMahon
Date Agreed	12 August 2015

Key Themes

Structure and function of the service

The peer review team was pleased to meet with good representation from all of the disciplines that constitute the Southern Health and Social Care Trust (SHSCT) urology multidisciplinary team (MDT) based at the Craigavon Area Hospital site.

The Urology configuration in Northern Ireland was reviewed and reorganised in 2009 to help address long waiting times and to move towards complying with the Improving Outcomes Guidance (IOG). Three urology cancer MDTs were agreed namely Southern, North West and the specialist MDT at Belfast. The County Fermanagh part of the Western Health and Social Care Trust (WHSCT) catchment area population was therefore included in the Southern Urology MDT and so the MDT covers a combined population of 409,832. The transfer of this work has been achieved relatively seamlessly as there was already a single urology team based on a single site at Craigavon. Some outpatient and diagnostic services are provided at South Western Acute Hospital (SWAH) in Enniskillen.

The MDT presented to the review team as being well led and with a vision for developments to

Received from Tughans OBO Mr Aidan O'Brien on 04/11/2022. Annotated by the Urology Services Inquiry

A. We do now.

83 Q. So one of the drivers for this seems to have been people's perception that the focus on performance was needed because that's what the HSCB and now SPPG or whoever is interested in, so these are mandated, whereas the focus on safety and quality wasn't mandated in the same way and, therefore, fell off because everyone was so busy. Do you think that is a fair thing, this is what has come up from some of the evidence? 11:41

A. I do.

84 Q. Yes.

A. I do indeed.

85 Q. What do you think the Trust should do about that?

A. We change the narrative, you know, and we do it when we talk. It has been as recent as the conversations with the Department of Health, we are talking about performance and safety as well. So we need to change the narrative about what we are actually focusing on here because, if you get the safety right, the performance will flow. 11:41

86 Q. Has the Board taken that discussion to understanding that, if you had regular information about the quality of services which - I would put safety as part of that, - there might be other things in it - that would help the oversight, because I can't see that conversation anywhere? And also, I think there hasn't been a national conversation to say 'we want to help trusts to do this'. Some of those things can come from national 11:42

audit measures that you already have, it is just a question of are they brought together in a way and does the Board recognise that better assurance like that would help its deliberations?

A. It does. 11:42

87 Q. The other thing, there has been a lot of evidence about MHPS and you have said that the MHPS reporting is much better and we can see that in the papers from the Governance Committee, do you think that there is a more rigorous approach now to management leadership for 11:42 medical staff and the importance of that and the investment in that? Because there seems to have been a lack of time for doctors to devote to management and leadership and a sometimes poor understanding of what they were doing, what has the Board discussion been 11:43 about that and has there been any funded program of work that the Board has been able to support or the Department has been able to support, what's happened in that arena?

A. The Senior Leadership Team have been having a 11:43 conversation team about management leadership across the Trust and through the HR Directorate then there will be, I suppose, a program of offering to be created. The Board hasn't been asked yet --

88 Q. Okay. 11:43

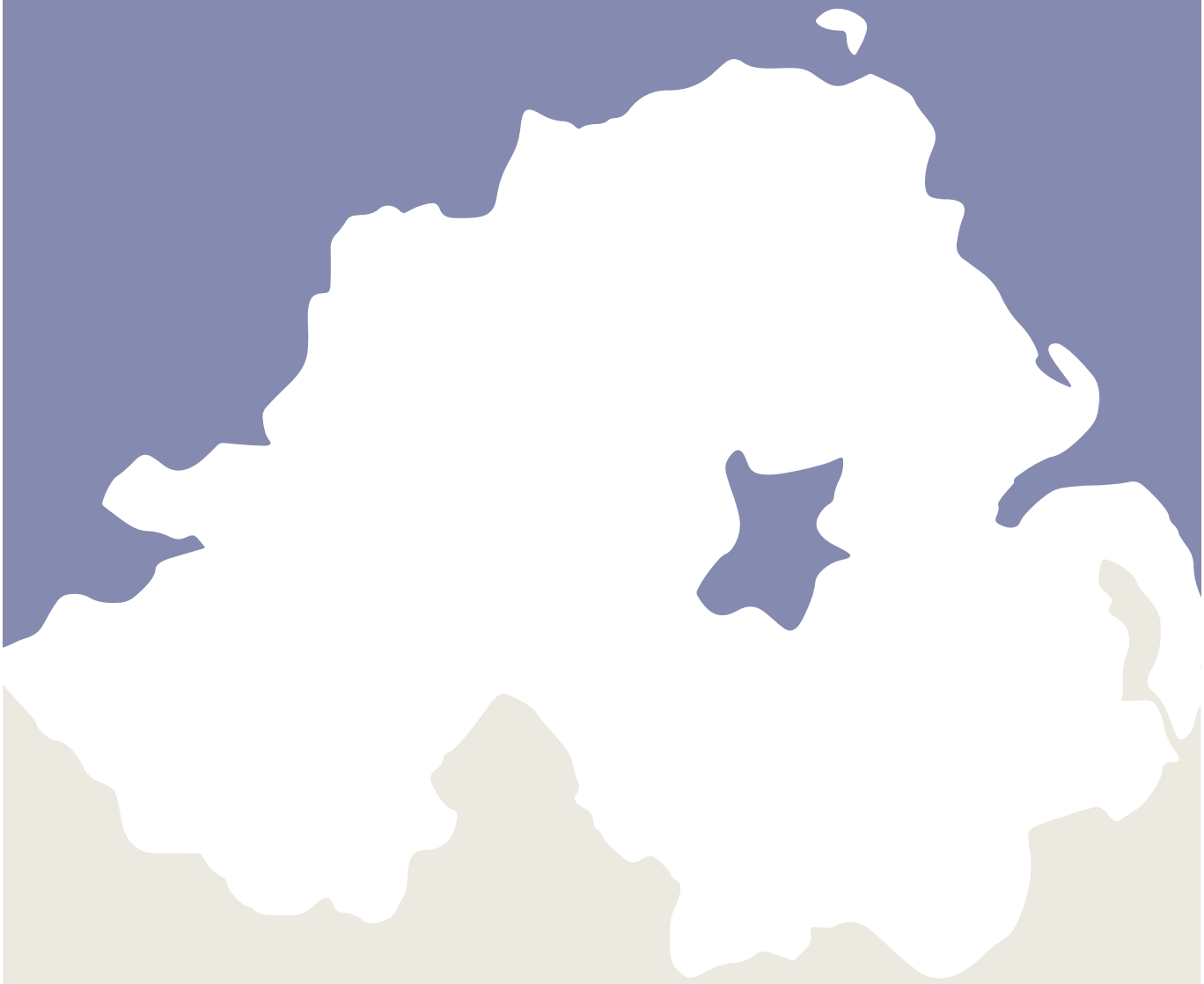
A. -- about the resources for that, but certainly the Board is very familiar that there is going to be work done now to bring in management and leadership across the Trust and the support that's needed to do that.

102 Q. It is actually rather helpful?
A. Yes, I would agree.
103 Q. Apart from anything else it means that people have somewhere to go, even if they have no real reason to do that, you know. So there seems to be in quite a few areas a sense of sort of helplessness about the whole demand capacity issue, and it's helplessness that's been there for years and an acceptance that, you know, periodically some cash comes down and you can do a bit more. How much fuss have people made, has the Board made, say, recently, for example, in terms of saying enough is enough, this is now a huge patient safety risk, something has got to be done, how can we work together, let's not wait for the outworkings of Bengoa or whatever it is, have you made a big fuss, has the Board made a big fuss, have other boards made a big fuss, what does it feel like? 11:49 11:50 11:50
A. I would agree with the helplessness, without a doubt, and we will just wait for a pot of money and everything will be sorted. I would say in the last year or so there has been a real impetus, these challenges will not change unless we do something and we can't wait on the white horse coming over with the money bags. So, certainly talking to my fellow chairs and hearing from the chief executives, there is a real focus on that right now with the Department through the Permanent Secretary Peter May. One of the examples I can provide you is the regional control centre has been set up for the ambulances right across all the Trust, so there is 11:50 11:51

THE RIGHT TIME, THE RIGHT PLACE

An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

DECEMBER 2014



Review Team | Sir Liam Donaldson | Dr Paul Rutter | Dr Michael Henderson

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

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1 CONTEXT

Throughout the developed world much healthcare is of a very high standard. The range of technologies and drugs available to diagnose and treat illness greatly increased during the second half of the 20th Century, and into the 21st, offering life and hope where patients' prospects were once bleak. As a consequence, the number of people living with disease and needing years or even decades of support from care systems has expanded enormously.

The ageing population of today is a central consideration in a way that was not foreseen when modern healthcare came into being in the aftermath of the Second World War. Today, people are living much longer and developing not just one disease but several that co-exist. In old age, the twin states of multi-morbidity and frailty are creating acute and long-term health and social care needs on an unprecedented scale.

Technology has continued its rapid and beneficial advance, opening up new opportunities for diagnosis and treatment but bringing even greater numbers through the doors of hospitals and health centres. Citizens experience the benefits of an advanced consumer society and when they encounter the health and social care system, they rightly expect it to be commensurate with this. Rising public expectations are a further driver of demand for healthcare. There are other, less predictable sources of pressure on services. For example, a change in the pattern of winter viruses can bring surges in demand that threaten to overwhelm emergency departments. In response to all of this, the size of budgets devoted to health and social care has had to expand dramatically.

At the epicentre of this complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make *their* experience, the outcome of *their* condition, *their* treatment, and *their* safety as good as it gets. Health and social care systems around the world struggle to meet this simple ideal. Evaluations repeatedly show that: variation in standards of care within countries is extensive; some of the basics such as cleanliness and infection are too often neglected; evidence-based best practice is adopted slowly and inconsistently; the avoidable risks of care are too high; there are periodic instances of serious failures in standards of care; and, many patients experience disrespect for them and their families, bad communication and poor coordination of care.

The health and social care system in Northern Ireland serves a population of 1.8 million. People live in urban, semi-rural or rural communities. Responsibility for population health and wellbeing, and the provision of health and social care, is devolved to the Northern Ireland Assembly from the United Kingdom government in Westminster. As in other parts of the United Kingdom, the Northern Ireland health service operates based on the founding principles of the National Health Service - the provision of care according to need, free at the point of access and beyond, funded from taxation. However, since the advent of devolved government, England, Scotland, Wales and Northern Ireland have adopted their own strategies for: promoting and protecting health; preventing disease; reducing health inequalities; and, planning and providing health and social care services. The countries have developed different structures and functions within their systems to meet these responsibilities. Thus, they vary in features such as: arrangements for planning and contracting of care; levels of investment in public health, primary and community care versus hospital provision; funding models; incentives; use of the independent sector; managerial structures; and, the role of the headquarters function.

Various agencies, groups and strategies populate the quality and safety landscape of Northern Ireland. Quality 2020 is the flagship

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

DOH-71941

ten-year strategy. Commissioned by the Minister of Health, Social Services and Public Safety in 2011, its vision is to make Northern Ireland an international leader in high quality, safe care. Quality 2020 is sponsored by the Chief Medical Officer and led by the Department of Health, Social Services and Public Safety. It has a steering group, a management group, an implementation team, project teams, and a stakeholder forum. These bring together representatives from across the statutory care bodies and beyond. Separately, a Health and Social Care Safety Forum convenes a similar group of stakeholders.

The Regulation and Quality Improvement Authority (RQIA) is the main regulator in Northern Ireland's care system. Many of the social care providers, and some healthcare providers, are registered with the Regulation and Quality Improvement Authority. However it does not register the Trusts, which provide the bulk of health and social care in Northern Ireland, or general practices. The Trusts' relationship with the regulator therefore has a somewhat softer edge than might be the case if they were formally registered, although an expanded role has been announced recently by the Minister.

Northern Ireland takes a keen interest in the work of quality and safety bodies elsewhere in the United Kingdom, and often implements their guidance and recommendations. The National Institute for Health and Care Excellence (NICE) and the former National Patient Safety Agency have been prominent in this regard.

Technical quality and safety expertise sits not in the Health and Social Care Board, but next door in the Public Health Agency. The Public Health Agency has a statutory role in approving the Health and Social Care Board's commissioning plans. Two executive directors are jointly appointed between the Public Health Agency and the Health and Social Care Board. There are therefore mechanisms through which quality and safety expertise should inform the Board's work. The Quality Safety Experience Group is jointly managed between these two agencies. It meets monthly and its primary focus is learning. It looks at patterns and trends in incidents and initiates thematic reviews.

In short, there is a good degree of activity in the sphere of quality and safety improvement. There are some unusual features of the landscape, which will emerge in some detail in this Review.

The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations.

The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future.

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

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2 TERMS OF REFERENCE AND WORKING METHODS

The Review's formal Terms of Reference are available online[1]. The overall aim of the Review has been to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

The analysis in this report is based on extensive input from, scrutiny of, and discussion with people across the health and social care system in Northern Ireland. Each of the main statutory organisations made formal submissions to the Review (including records of board meetings, policies, and plans). The Review put substantial emphasis on travelling around the system – both literally and figuratively – to see it from as many different angles as possible, and to come to a rounded view.

The Review Team visited the five Health and Social Care Trusts, the Northern Ireland Ambulance Service, the Department of Health, Social Services and Public Safety, the Health and Social Care Board (and its Local Commissioning Groups), the Public Health Agency, the Patient and Client Council, and the Regulation and Quality Improvement Authority. In each, the Review Team met with the executive team (Chief Executive and executive directors) and, in most cases, the Chair of the Board and other non-executive directors. The management team of each organisation gave a series of presentations covering the areas of interest to the Review, and Review Team members asked questions and led discussion.

During their visit to each Health and Social Care Trust and to the ambulance service, Review Team members also led focus groups discussions amongst frontline staff. In each of the five Health and Social Care Trusts, for example, the team met with separate groups of consultants, nurses, junior doctors, and other health and social care professionals. Senior managers were not present for these discussions. Participants were encouraged to speak openly, and generally did so. It was understood that no comments would be attributed to individuals. The focus groups centered on any concerns about quality and patient safety in their organisation and incident reporting, and other highly-related topics. The team also met with two groups of general practitioners.

The Review Team paid particular attention to the experiences of people who have come to harm within the Northern Ireland health and social care system. At each Trust, including the ambulance service, the team reviewed two recent Serious Adverse Incidents in detail, particularly considering the incident itself, the way in which patients and families were kept informed and involved, and the learning derived. The team later returned to two Trusts to review further incidents, this time selected by the Review Team from a list of all serious adverse incidents in the previous year. The Review Team met with people who have come to harm. Most of these meetings were in person; some were by telephone. In addition to people affected directly, the Review Team spoke to their family members and carers. We are particularly grateful to all of these individuals for giving of their time, and for graciously sharing their stories with us, which were often painful.

Finally, the Review Team met with a series of other individuals and groups that form part of the wider health and social care system in Northern Ireland, or have a strong interest in it. These were: the Attorney General, the British Medical Association, the Chest Heart and Stroke Association, the Commissioner for Older People for Northern Ireland, Diabetes UK, the General Medical Council, MacMillan Cancer Support, the Multiple Sclerosis Society, the Northern Ireland Association of Social Workers, the Northern Ireland Human Rights Commissioner, the Northern Ireland Medical & Dental Training Agency, The Honourable Mr Justice O'Hara,

[1] http://www.dhsspsni.gov.uk/tor-080414.pdf

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

the Ombudsman for Northern Ireland, the Pain Alliance of Northern Ireland, Patients First Northern Ireland, the Royal College of Nursing, and the Voice of Young People in Care. Other patient and client representative groups were invited to meet with the Review Team, or to make written submissions.

To inform one aspect of the Review, the Regulation and Quality Improvement Authority oversaw a look-back exercise, reviewing the handling of all Serious Adverse Incidents in Northern Ireland between 2009 and 2013. Their report was received late in the Review process, but has been considered by the Review Team and reflected in this report.

Between starting and producing its final report, the Review Team has had a relatively short period of time. It has not been possible to undertake research, extensive data analysis, large-scale surveys of opinion, or formal evidence-taking sessions. However, the documents reviewed, the meetings held, the visits made, and the views heard have given a strikingly consistent picture of quality and safety in the Northern Ireland health and social care system. The Review Team is confident that a longer exercise would not have produced very different findings.

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

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3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

Patients in hospitals and other health and social care services around the world die unnecessarily, and are avoidably injured and disabled. This sad fact has become well known since the turn of the 20th Century. Awareness of it has not been matched, unfortunately, by effective action to tackle it.

There is consistency in the types of harm that occur in high-income countries. In low-income countries, harm is mainly related to lack of infrastructure and facilities, as well as poor access to care. However, in North America, Europe, Australasia, and many parts of Asia and the Middle East, analysis of incident reports and the findings of patient safety research studies shows a different, strikingly consistent pattern. Between 3% and 25% of all hospital admissions result in an adverse incident, about half potentially avoidable. Within any health or social care service, there are many potential threats to the quality and safety of the care provided:

1. Weak infrastructure - the range and distribution of facilities, equipment and staff is inadequate to provide fair and timely access to required care.
2. Poor co-ordination - the components of care necessary to meet the needs of a patient, or group of patients, do not work well together to produce an effective outcome and to be convenient to patients and their families.
3. Low resilience - the defences in place, and the design of processes of care, are insufficient to reliably protect against harm such as that resulting from errors or from faulty and misused equipment.
4. Poor leadership and adverse culture - the organisation or service providing care does not have clear goals and a philosophy of care that it is embedded in the values of the organisation and visible in every operational activity.
5. Competence, attitudes, and behaviour - the practitioners and care-providers working within the service lack the appropriate skills to deal with the patients that they encounter, or they are unprofessional in their outlook and actions, or they do not respect other team members, nor work effectively with them.
6. Sub-optimal service performance - the way that the service is designed, organised and delivered means that it does not deliver processes of care to a consistently high standard so that over time it chronically under-performs often in a way that is not noticed until comparative performance is looked at.
7. Slow adoption of evidence-based practice - the service does not conform to international best practice in particular areas of care or overall.

The amount of each type of harm varies but the overall burden has changed little over the last decade despite the unprecedented priority that has been given to patient safety within these health systems. Little is known about the level and nature of harm in primary care, though more attention is now being given to it.

Although these threats are described in relation to health, they apply also to social care. Many are strongly related to the level of resources that is available to a health and social care system. The extent to which each problem is present varies hugely across the world, within countries, and even between different parts of the same service or area of care provision.

In some ways it is reassuring to believe that the problems of quality and safety of care are somehow universal, and that no country has the answers. This is dangerous thinking. The best services in the world show that even with the all the pressures of large numbers of patients, many with complex needs, excellence can be achieved consistently across all fields of care. The Northern Ireland health and social care service must not be satisfied with 'good enough.' With a clear recognition of the reasons for its current problems in quality and safety of care, and with everyone working together, it could be amongst the best in the world.

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

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4 KEY THEMES ESTABLISHED BY THE REVIEW

The Review established six key themes. Each is set out in some detail below. Exploration of these themes provides the basis for the Review's conclusions (in section 5) and recommendations (section 6).

4.1 A SYSTEM UNDER THE MICROSCOPE

Northern Ireland's health and social care system is subject to a high, perhaps unrivalled, level of media coverage – much of it negative. Over recent years, it has also been the subject of a series of high profile inquiries. All have highlighted numerous failings in the leadership and governance of care. Many have made extensive recommendations and the extent to which these have been implemented has itself been controversial. The pressures of increasing demand for care have meant that access has been more difficult. There has been a focus on over-crowding and delays in emergency departments, the front door of the hospital service. All of this has meant that the last five years has been a period of unprecedented scrutiny of the way that health and social care in Northern Ireland is planned, provided and funded.

4.1.1 A stream of inquiries highlighting service failures

The number of recent major investigations and inquiries into shortfalls in standards of care in health and social care services in Northern Ireland is striking in relation to the size of its population. This does not necessarily mean that such occurrences are commoner than elsewhere in the United Kingdom. It may simply be that the level of public and media scrutiny is higher and the pressure from this triggers a statutory response by government ministers and officials. The end-result is that the profile of the service is more often one of failure rather than success.

In March 2011, Dame Deirdre Hine, a former Chief Medical Officer for Wales, issued the report of her inquiry into deaths from *Clostridium difficile* in hospitals in the Northern Trust area. She had been brought in to investigate 60 deaths that had been attributed to the organism. She found that the true figure was 31 deaths. She found management, organisational, clinical governance and communication failings. She made 12 recommendations. It took 23 months to complete.

In February 2011, the Belfast Trust recalled 117 dental patients following a review of the clinical performance of a senior consultant. An independent inquiry commissioned by the Minister was published in July 2013 and made 45 recommendations. An action plan developed by the Department of Health, Social Services and Public Safety identified 42 key actions including on staffing, training, supervision and clinical governance. In November 2013, the Regulation and Quality Improvement Authority conducted an assessment of implementation of those actions.

In December 2011, an independent report by the Regulation and Quality Improvement Authority examined delays in the reporting of plain X-rays in all Trusts after concerns were expressed about delays in two hospitals. The review found that serious delays had occurred and were caused by three main factors: a shortfall in consultant radiology staffing, a growth in numbers of x-rays to be reported after the introduction of digital imaging and the introduction of a new policy to report on all hospital chest x-rays because of worries about patient safety. The review found that there was little awareness at regional level that a serious backlog in reporting was developing with potential risks to patients due to delayed diagnosis. The review made 14 recommendations.

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In May 2012, Doctor Pat Troop, former chief executive officer of the Health Protection Agency in England, issued her final report of the independent investigation into an outbreak of infections in neonatal units due to the organism *Pseudomonas aeruginosa*. Five babies had died in the outbreak and 32 recommendations were made covering technical matters, management, governance, communication, training, and outbreak management.

In April 2012, the Minister asked for special measures to be put in place to oversee the Belfast Trust because of major concerns about serious adverse incidents in the emergency department, recommendations from the Pseudomonas review, reviews of paediatric congenital cardiac surgery and recommendations of the dental inquiry.

In December 2012, the Minister appointed a Turnround and Support Team to go into the Northern Health and Social Care Trust because of concerns about the weakness of governance and quality assurance systems, the paucity of clinical leadership, and uncertainties about the reliability of mortality data. This particular Trust has had five chief executive officers in the last seven years.

In June 2014, the Regulation and Quality Improvement Authority reported on its review of unscheduled care services in the Belfast Trust. The concerns that led to the review included: the declaration of a major incident, 12-hour waiting time breaches, dysfunctional patient flows and gross overcrowding of patient care areas. This triggered a fuller review that looked at matters region-wide. This produced 16 recommendations.

The dominant inquiry in recent times remains the *Independent Inquiry into Hyponatraemia–Related Deaths*. It is examining the deaths of children after being transfused in hospital with a fluid that was subsequently found to carry a significant risk. Concerns had been raised by the parents and others that this risk should have been identified much earlier, that action should have been taken to stop it being used, that there was a cover-up and that systems for monitoring safety were inadequate. It is being chaired by John O'Hara QC and was commissioned in 2003/4 but, because of other legal processes, was not able to hear full evidence until more recently. The report is expected in 2015.

The criticisms in inquiries like these have been largely justified and must be followed by action to improve the situations. Whether establishing formal, often lengthy, and costly inquiries is the right way to drive improvement is very debatable. Certainly doing so as the normative response to failure has important disadvantages. In particular, it often paralyses the organisation under scrutiny as its staff become pre-occupied with preparing evidence and supplying information. The learning is often put on hold - sometimes never to be returned to - until the inquiry is over. The burden of recommendations to be implemented and progress-checked can be overwhelming, so that the implementation becomes a bureaucratic exercise rather than a watershed moment for leadership, culture and the content of practice. It might be better to define a clear threshold for when a full-blown inquiry is initiated.

4.1.2 Intense political and media interest in service provision

Northern Ireland's health and social care system is subject to a high degree of political, as well as media, interest. This is a valid and expected feature of a publicly-funded system. Ironically, though, the way in which this interest becomes manifest often creates results that are counter to the true public interest. There have been many examples of local communities – and therefore their politicians – wanting to keep a local hospital open, contrary to the analysis of service planners. This has created

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a situation in which Northern Ireland has more inpatient units than is really justified for the size of population, and the expense of maintaining them impedes provision of other services that would represent better value for money and more appropriately meet the needs of the population. Likewise, political pressure and media interest has prevented the salaries of top managers from being raised too substantially. However, senior executives in the Northern Ireland care system are now paid much less than their counterparts elsewhere in the United Kingdom. The public would be better served if their care system could compete to attract the very best managerial talent. The pressure to keep salaries down may be penny-wise and pound-foolish.

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

4.2 THE DESIGN OF THE SYSTEM HINDERS HIGH QUALITY, SAFE CARE

When a quality or safety problem arises somewhere within the Northern Ireland care system, the tendency is to point to the individuals or services involved, and to find fault there. As with so many other features identified in this report, this tendency is far from unique to Northern Ireland. But it represents, in the view of the Review Team, too narrow a focus. In reality, the greatest threats to the quality of care that patients receive, and to their safety, come from the way in which the system as a whole is designed and operates.

In short, the services that exist are not the services that the population truly requires. Political and media pressure acts to resist change, despite the fact that change is much needed. It is not clear who is in charge of the system, and the commissioning system is underpowered. All of this compounds the pressures, creating high intensity environments that are stressful for staff and unsafe for patients – particularly out of hours. These effects are explored further below.

The Northern Ireland care system has some elements in common with the other United Kingdom countries, and some that differ. Observers, asked to describe the Northern Ireland system, often point first to the integration of health and social care as its distinguishing feature. It is clear though from the findings of this Review that whilst the integrated design of the system has great advantages, it falls well short of perfection in promoting the highest standards of care and in preventing the dysfunctions in the co-ordination of care that are prevalent elsewhere.

4.2.1 Service configuration creates safety concerns

A striking feature of the provision of care in Northern Ireland is the wide distribution of hospital-type facilities outside the major city, Belfast, some serving relatively small populations by United Kingdom standards. This geographical pattern leads to specialist expertise being too thinly spread, and to the patchy availability of experienced and fully competent staff. It means that it is not possible everywhere to deliver the same quality of service for an acutely ill person at 4 a.m. on a Sunday as at 4 o'clock on a Wednesday afternoon. There is therefore a two-tier service operating in Northern Ireland - in-hours and out-of-hours - that is more pronounced in some places than in others. This is one of the biggest influences on the quality and safety of care. Delivery of services is too often higher risk than it should be in a 21st Century healthcare system because of the pattern of services.

Past analysts and observers have pointed to the current level and siting of provision not being in keeping with maintaining high standards of care. Some populations are just too small to warrant full-blown general hospital facilities yet they are kept in place because of public and political pressure. Amongst those who work within the system, there is deep frustration that the public are not properly informed about the higher risks of smaller hospitals and that the misapprehension that alternative forms of provision are in some way inferior to a hospital. These issues are illuminated by two wry comments made to the Review: "the word 'hospital' should be removed from the Oxford English Dictionary" and " Northern Ireland needs more roads not more hospitals."

Despite its small size, there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme. The Health and Social Care Board runs regional commissioning teams, covering areas such as learning

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

disability, mental health, prison health and a very broad category of 'hospital and related services'. However, particular scope exists to do more in improving standards in areas of clinical care where there is a strong evidence base for what is effective. In the cases where clinicians have worked together across organisational boundaries, remarkable transformations have occurred. This happened in cardiology where a regionally planned and coordinated service means that more patients with heart attacks get treated early, get less damage to their hearts, and more people live rather than die. The Ambulance Trust is the only one of the six Trusts organised on a regional basis. The Review Team was very struck by how much pressure this important service was under. This is consistent with the headline stories in other parts of the United Kingdom about ambulance services being unable to meet their service standards because of huge surges in demand. All parts of the service are taking the strain – from those in the control centre to those on the road. Yet when the detail of their situations is explored in depth, it is clear again that the problems stem from dysfunctional patient flows and pathways where different parts of the system are not working together.

4.2.2 Adverse consequences for primary and social care

The pressures on hospitals have consequences for primary and community services. There is a constant need for hospitals to discharge patients as soon as they possibly can to free-up beds for new admissions. Generally, this happens when an older person is judged medically fit for discharge. However, this does not necessarily mean that their physical and social functioning has reached a level where they can cope with a return to the community. The Review was told by general practitioners and social care staff that they often have to step in to provide unscheduled support in such circumstances and, because of inadequate communication at the time of discharge, they can be left in the dark about ongoing treatment plans and even be unclear about something as basic as a patient's medication regime. Some general practitioners spoke of spending long, frustrating hours trying to get to speak to a hospital doctor about their patient, without success.

Over the last decade, there has been a major increase in the dependency levels of people being cared for in the community. For example, the use of PEG feeding (directly into the stomach through a tube in the skin) is now commonplace in community settings, whereas it used to be a hospital treatment. As a result, community nursing staff have much more complex caseloads. There is also greater complexity in the other forms of disability, as well as in the treatments that people are receiving and other technologies that are supporting them.

The Review Team was very struck by the experience of one on-call pharmacist whom they talked to. He was responsible for preparing the discharge medication for patients leaving hospital on a particular Bank Holiday weekend. He reported filling a doctor's prescription for 20 different medications for each of four patients. This strongly illustrates several points. Firstly, it is not right that such an excessive amount of medication should be routinely prescribed. It should be rigorously reviewed and adjusted. Secondly, it again shows the complexity and multiple conditions affecting many patients, who move regularly between hospital and community. Thirdly, it highlights the opportunity for a much stronger role for under-appreciated disciplines like pharmacy on the boundary between hospital and population.

The integration of health and social care means that the Review Team's discussions within Trusts necessarily took account of the important role of social care staff, and particularly social workers. They are a vital part of the workforce and although under equal pressure to their

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healthcare counterparts, the Review was encouraged to hear about the strong emphasis on professional development in Northern Ireland and the particular expertise in specialist areas such as adult safeguarding.

The knock-on effects of pressures in the hospital system for community services are not restricted to post-discharge matters. Many hospital departments are so pre-occupied with urgent work and the high volume of patients that they do not have time to provide proper responses when patients or their doctors make contact to ask about progress with an outpatient appointment or test results.

4.2.3 High-pressure environments fuel risk to patients and sap morale

The demand from patients who need emergency care, as well as those who require planned investigations and treatments, is extremely high. The pressures on emergency departments and hospital wards are very great. Over-crowded emergency departments and overflowing hospital wards are high-risk environments in which patients are more likely to suffer harm. This is because delays in assessment and treatment occur but also because staff have to make too many important and difficult decisions in a short space of time - what psychologists call cognitive overload. That they will make mistakes and misjudgments is inevitable, and some of them will be in life-and-death areas. Experience in other safety-critical industries, and research, shows that high-pressure, complex, and fast-moving environments are dangerous. If inadequate staff levels are added to the mix, risks escalate further.

The Review met with many groups of health and social care staff, speaking on condition of anonymity. They are overwhelmingly conscientious people who feel deeply for their patients and want to excel in the care that they deliver. Yet, the workloads in some situations are unacceptably high; so too are stress levels. The stress comes not only from the large numbers of cases per se, but much more from the feeling of staff that they are not giving patients the quality of care they were trained to deliver. There is guilt too in knowing that they are forced to compromise their standards to levels that they would not accept for their own families. The phrase "doing just enough" was repeatedly used in the Review's meetings with front-line staff. There are extra pressures for some groups of staff. Doctors in training can find themselves in situations that are beyond their competence and experience. Sometimes they can call on back-up from senior staff, sometimes they have to do their best until the morning or Monday comes. Some nurses can find themselves dealing with an unacceptably large number of patients on a hospital ward at night. They too feel that they are having to lower their professional standards. This assessment is not based on isolated anecdotes but much more widespread and consistent accounts.

4.2.4 Transformation efforts are moving slowly

Transforming Your Care began as a substantial review of health and social care provision in Northern Ireland, commissioned in 2011. The review was led by the then-Chief Executive of the Health and Social Care Board, supported by an independent panel. It was a strong, forward-thinking piece of work.

The whole of the United Kingdom, like most developed countries, has a fundamental problem: the health and social care system that it has is not the health and social care system that it needs. The pattern of ill-health in the population has changed substantially since the systems were founded, and the systems have not changed to keep up. *The Transforming Your Care review* set out a convincing case for change. It described inequalities in health, rising demands, and a workforce under pressure. It particularly established that Northern Ireland has too many acute hospitals

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- that elsewhere in the United Kingdom, a population of 1.8 million people would likely be served by four acute hospitals – not the 10 that Northern Ireland had.

Transforming Your Care set out a broad new model of care, which aimed to be tailored to today's needs and person-centered. In practical terms, its most substantial proposal was to move £83 million away from hospitals and give it to primary, community and social care services.

Those interviewed by this Review Team unanimously supported the need for this initiative. The widespread feeling, though, is that *Transforming Your Care* is simply not being implemented.

As a result of weak communication and little action, there is substantial skepticism about *Transforming Your Care*. The Review Team heard it variously referred to as "Transferring Your Care", "Postponing Your Care", and even "Taking Your Chances". One of its central concepts, 'shift left', is viewed particularly warily. Carers see it as a euphemism for dumping work onto them; general practitioners likewise. Those working in the community see their workload increasing, and worry that there is no clarity at all about what the overall care model is supposed to be.

The frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations. General practices themselves are financially contributing to these, in a move to establish community-centered care pathways.

The needs that *Transforming Your Care* sets out to address are becoming ever more pressing. Its implementation needs a major boost in scale and speed, and communication needs particular attention.

4.2.5 An under-powered system of commissioning

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. In addition to the Department of Health, Social Services and Public Safety, there are six Trusts, a Health and Social Care Board with five Local Commissioning Groups, a Public Health Agency, and several other statutory bodies.

A central feature is the split between care providers and commissioners, which increases the complexity of the system and its overhead costs. This began life as the so-called purchaser-provider split, introduced by Margaret Thatcher's government in the late-1980s. In various iterations, it has remained a feature of the NHS ever since. The introduction of a purchaser-provider split was originally intended to create a competitive 'internal market' to drive up quality and so increase value for money. However, the scope for genuine competition has always been very limited. The term 'commissioning' subsequently superseded 'purchasing'. Commissioning involves a wider set of functions – assessing need and planning services accordingly, and the use of financial incentives to intentionally drive the system's development relating to the type of services provided, their quality and their efficiency.

Within the United Kingdom, the English NHS has the most developed commissioning system. NHS England, the national commissioning board, is now separate from the central government Department of Health. It is a pure commissioning organisation, completely free from overseeing the performance of Trusts. Its only relationship with the provider side of the market is through the commissioning process. It devolves the vast majority of funds to local Clinical Commissioning Groups (of general practitioners) that make decisions about the allocation of money against a national

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

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framework of policies and goals. Services are priced under a tariff system. This tariff has become increasingly complex, to facilitate locally agreed variation and to incorporate pay-for-performance elements.

There are several contextual differences between England and Northern Ireland, of which the most obvious is population size. In England, the overhead costs associated with establishing and administering a complex tariff system are essentially divided between 53 million people. With a population one-thirtieth the size, the cost per head of running a similar system in Northern Ireland would be difficult to justify.

The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland has no service tariffs. The Health and Social Care Board allocates money by a process akin to block contracting. This approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic. Staff the Review Team spoke to believed that it makes no distinction, for example, between a cystoscopy (a simple diagnostic procedure, usually a day case) and a cystectomy (a complex operation), a clear absurdity if true.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

It is imperative, somewhere in the system, for needs to be assessed, services planned and funds allocated. Whichever part of the system is responsible for this must be sufficiently resourced to do it well – arguably, the Health and Social Care Board is currently not.

The Northern Ireland system would benefit from stronger thought- leadership from within. There is no established health and social care think-tank, and some key disciplines such as health economics are not strongly represented.

Northern Ireland could choose to go down any number of different routes. It could strengthen the current Health and Social Care Board, particularly to create a tariff that includes a strong quality component. Alternatively, it could devolve budgetary responsibility to the five Trusts, making them something akin to Accountable Care Organisations in other countries, responsible for meeting the health and social care needs of their local population. The Trusts would then buy in primary care services, and contract between themselves for tertiary care services.

Recommending a commissioning model is beyond the scope of this Review. It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided. For that reason, the Review Team must recommend that this issue be addressed.

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4.2.6 Who runs the health and social care system in Northern Ireland?

It was instructive for the Review Team to have asked this question of many people. The question elicited a variety of answers, the common feature of which was that no one named a single individual or organisation. Indeed, most reflected their uncertainty with an initial general comment. Typical was a remark like: "The Minister has a high profile."
When pressed to directly answer the question: who runs the service? Their answers included: "The Minister", " The Permanent Secretary in the Department of Health", " The Chief Executive of the Health and Social Care Board", and " The Director of Commissioning of the Health and Social Care Board."

These responses reflect the complexity of the governance arrangements at the top of the health and social care system in Northern Ireland. They show that ambiguity has been created in the minds of people – both clinicians and managers – throughout the system.

The question of who is in charge is both simple and subtle. Whilst overall accountability versus calling the shots versus making things happen are aspects of governance that would have a single leadership locus in many places, this is not the case in Northern Ireland. There is no single person or place in the organisational structure where these things come together in a way that everyone working in the service, the public and the media clearly understand.

The present arrangements have evolved over time but the Review of Public Administration in 2007 led to many of them. Prior to this the Department of Health, Social Services and Public Safety was larger and oversaw four Commissioning Boards and 18 Trusts. There were highly-centralised control mechanisms and the service was subjected to many and frequent circulars and directives. Since then there has been a smaller Department of Health, Social Services and Public Safety that is more focused on providing policy support to the Minister. A single Health and Social Care Board has been created from the previous four. The number of Trusts has been reduced from 18 to six, five organised to provide health and social care services by geographical area and the sixth an ambulance Trust for the whole region. Another important change has been the advent of a fully-devolved administration and the end of direct rule where power was in the hands of civil servants rather than elected local politicians. The lack of clarity about who is in charge is a major problem for Northern's Ireland care system. The difficulty is not that there is no figurehead, but that strategic leadership does not have the visibility of other systems. Without a clear leader, progress is piecemeal and change is hesitant and not driven through at scale – the Review Team was told "there are more pilots than in the RAF".

4.2.7 Clarifying the role of healthcare regulation

Aside from being commissioned by the Department of Health, Social Services and Public Safety to conduct occasional service-specific inspections, the Regulation and Quality Improvement Authority has until now conducted a program of thematic reviews driving more at quality improvement than at regulation.

From 2015, the Minister has decided that the regulator should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland. The Regulation and Quality Improvement Authority is being directed in this task to examine selected quality indicators in relation to triage, assessment, care, monitoring and discharge. As a result of this change, the regulator will reduce its normal annual programme of thematic reviews.

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

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These changes give the Regulation and Quality Improvement Authority a much stronger locus in the healthcare side of provision. However, this body has no real tradition of doing this kind of work, unlike its counterparts elsewhere in the United Kingdom. For example, in England, the various health regulators have evolved over a 15-year period with frameworks, methodologies, metrics and inspection regimes. For this reason, the Review is recommending that healthcare regulation in Northern Ireland is re-examined in the round, rather than approaching it piecemeal on an initiative basis.

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

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4.3 INSUFFICIENT FOCUS ON THE KEY INGREDIENTS OF QUALITY AND SAFETY IMPROVEMENT

The recognition that quality and safety should be a priority in the planning and delivery of health and social care arrived late to this sector in developed nations. Until the early 1970s, services operated on the tacit understanding that doctors' and nurses' education, training, professional values and standards of practice ensured that most care was good care. It was not until measurement of quality became more commonplace that it was realised that faith in this ethos had been badly misplaced. A series of scandals blew apart public confidence in the NHS. There were many victims, and it became clear that trust alone was not sufficient. Often, such events depicted cultures in some health and social care organisations in the United Kingdom and other countries that had tolerated poor practice and even sought to actively conceal it.

Organised programmes to assure quality and improve it initially came into healthcare through approaches developed in the industrial sector, notably total quality management and continuous quality improvement. Until 1998, there had never been a framework to progress quality and patient safety in the United Kingdom's NHS. From that time, a comprehensive approach was introduced with: *standards* set by the National Institute for Clinical Excellence and in National Service Frameworks; a programme of *clinical governance* to deliver assurance and improvements at local level backed up by a statutory duty of quality; and, inspection of standards and *clinical governance* arrangements carried out by the Commission for Health Improvement. These roles have changed over time. Some still cover all, or most, of the United Kingdom, whilst others have been taken up differently in the four countries.

Much recent commentary on the NHS in the United Kingdom has focused on whether its leadership is really serious about quality and safety. There is a widespread view within the service that financial performance and productivity are what really matter to managers, despite what might be in the mission statements of their organisations. This came home to roost in the scandalous events at the Mid-Staffordshire NHS Trust in England where the Francis Inquiry heard that concerns about quality were down-played against financial viability in the pressure to gain Foundation Trust status.

A key consideration in quality and safety of healthcare is whether it is embedded in the mainstream at all levels. Up until the late-1990s, it was largely the domain of academics and enthusiasts. Since then, those who are fully committed to its underlying principles and goals have increased in number. However, it is still debatable what proportion of board members, management teams, and clinical leaders are 'card-carrying' quality and safety enthusiasts.

Prominent in international experience are four essential ingredients to improving the quality and safety of care. These are: clinical leadership, cultural change, data linked to goals, and standardisation. In Northern Ireland seeds of each can be found, but none is blossoming. This is substantially holding Northern Ireland's care system back from achieving its full potential.

4.3.1 Clinical leadership

A crucial test of the strength of the quality and safety system is the extent of clinical engagement. This is partly a question of hearts and minds but also a case of knowledge, skills and the philosophy of clinical practice.

The quality and safety of care will only get better if those who deliver the care are not only *involved* in improving it, but are *leading* the improvement effort. In the very best healthcare

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

systems in the world, clinicians are in the driving seat, supported by skilled managers. Traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Rightly, this remains the important primary requirement for establishing a culture of good clinical practice. However, this is not enough to enable consistently high standards of care, nor to make care better year-on-year. This requires a paradigm shift in clinical practice, a different mission of practice, so that all healthcare professionals see the essence of their work not just in the care of individual patients but in ensuring that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Accomplishing this is not easy. Clinicians will point out that their workloads are too heavy to make time to reflect on these wider considerations or that they do not have access to reliable data to allow them to compare their service to best practice or that they have not had training in quality and safety improvement.

Clinicians need to step forward to lead. This involves expanding their sense of responsibility beyond the individual patient in front of them to the system as a whole. When clinicians do step forward, they need to be supported. They need to be given responsibility and resources. They need to be given training, because leading improvement is technically and emotionally difficult.

In Northern Ireland, the Review Team met a small number of talented clinicians who have decided to step forward, and who are succeeding in leading positive change. The Review Team met many more clinicians who have tried to engage with 'management' in the past, have been knocked back, and have given up trying. There are many great ideas lying latent in the heads and hearts of clinicians, untapped by the system. The Review Team saw some effort, particularly in the South Eastern Trust, to provide clinicians with the skills that they need to lead improvement projects. Across the system as a whole though, the scale and scope of these is nowhere near what is needed.

4.3.2 Cultural change

Culture determines how individuals and teams behave day to day. It determines how clinicians view and interact with patients; whether they consider harm to be "one of those things", "the cost of doing business", or a feature of healthcare that, with effort, can be banished; whether they react to seeing problems in the system by complaining, or by taking on responsibility for fixing them.

All healthcare systems in the world realise the importance of culture. The difference between the best and the rest is what they do about this. The very best do not hope that culture will change; they put major effort into actively changing it. Their approach is not light-touch or scattergun; they see changing culture as a central management aim.

The Cleveland Clinic in the United States of America, for example, set out to improve patient experience, most of which is determined by how staff behave towards patients. The Clinic's management wanted all staff to better work as a team, and to see their role as being important for patient care – from doctors and nurses, to cleaners, receptionists and electricians. They designated them all 'caregivers'. All 40,000 caregivers attended a series of half-day training sessions, designed to build their practical communication skills and their awareness of self, others and team. They made patient experience scores widely available – ranked by doctor, by hospital, and by department. These efforts have continued for several years. In 2013, the Chief Executive's annual address to all caregivers included a powerful video about empathy. It has since been viewed 1.8 million times on YouTube. In short, the Cleveland Clinic made a major concerted effort to make patient experience important to all who work there.

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

It has paid off. With staff now more engaged than ever, the Cleveland Clinic has been able to move on to making safety and other elements of quality a crucial part of the culture too.

In Northern Ireland, as in many places, no effort has been made to influence culture on anything like this scale. Many people in the system are able to describe the culture, and many cite it as important. Scattergun efforts are made – a speech here, an awards ceremony there – but shifting culture is hard, and scattergun will not do it. Culture is viewed with a degree of helplessness – but the evidence from elsewhere is that it can be changed, and that doing so is powerful.

4.3.3 Data linked to goals

The importance of data and goals are news to nobody. Yet in Northern Ireland, as in too many other healthcare systems, data systems are weak and proper goals are sorely lacking.

Improving healthcare requires clear and ambitious goals. It requires a statement that preventable harm will be reduced to zero, or that the occurrence of healthcare associated infections will be cut in half within a year. Management guru Jim Collins would call these BHAGs – Big Hairy Audacious Goals. They are goals that are at once exciting and scary. They get people interested and motivated. They are the kind of goals that Northern Ireland should be setting for its care system.

If the goal is the destination, strong data are the sat nav. They show the current position in a form that provides useful information for action. Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level.

As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends.

4.3.4 Standardisation

Doctors generally dislike standardisation (nurses warm to it more), but it is a crucial part of improving the quality and safety of healthcare.

One healthcare standardisation tool is the World Health Organization's Safe Surgery Checklist. Modelled after the checklists that pilots use throughout every flight, it lists a series of simple actions that should be taken before the patient receives anaesthetic, before the operation starts, and before the patient is moved from the operating theatre. Each item on the list is something blatantly obvious – checking the patient's identity, confirming the type of operation that is planned, and so forth. Without the checklist, each of these things is done most of the time – but not all of the time. The checklist ensures that they are done all of the time – to avoid the occasional instance, as happens, in which nobody properly checks the operation type, and the patient has the wrong operation.

Care bundles are a concept that in recent years have brought higher quality to the areas of care where they have been used well. They help clinicians to reliably give every element of best practice treatment for common conditions such as pneumonia. The evidence is clear: they save lives. Without them, patients get best, safest practice only some of the time and those who do not are the unlucky ones who can suffer greatly as a consequence.

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

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Checklists and care bundles are not widespread in healthcare primarily, because they are counter-cultural. Doctors' training, in particular, emphasises the importance of retaining knowledge, of autonomy, and of variation between patients. All of these go against the idea of standardisation.
The concept of standardisation does not just relate to novel methods like checklists or care bundles. It is also concerned with all patients with a particular disease receiving a consistent process of care based on best practice internationally. The idea that people with conditions like bowel or oesophageal cancer should be receiving different treatment based on clinical preference or where they live is a disgrace. Healthcare should not be a lottery.

The best healthcare systems in the world have a high degree of standardisation. Not for everything – but for the areas of care where the evidence shows that it makes a difference. They have a substantial number of care pathways, checklists, and care bundles. This does not leave the clinicians without a job – far from it. Their judgement is vital in deciding which pathway, checklist or care bundle to use, and in spotting the cases in which a standard approach is not appropriate. They still spend the majority of their time working without reference to any of these things, but use them whenever they are needed.

Northern Ireland has some good examples of work in this area, including the rollout of a National Early Warning System for acutely ill patients, a care bundle for sepsis, an insulin passport, and regional chest drain insertion training. However, the opportunity for standardisation is much greater and needs to be applied at a more fundamental level, which influences the model of practice beyond this series of individual initiatives. There is not yet a critical mass of clinicians clamouring for more standardisation. There are multiple examples of different Trusts approaching the same clinical scenario in different ways, and wanting to retain their autonomy to do so. If Northern Ireland wants to be anything like as good on safety, clinical effectiveness and patient experience as the Cleveland Clinic and other centres of excellence, it needs to be more open to big change.

4.3.5 The recipe for success

There is little doubt that quality and safety are not fully embedded in the planning, design and delivery of services in Northern Ireland. More sleep is lost over budgets than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

Four vital, and often superficially treated, ingredients for quality and safety improvement are: clinical leadership, cultural change, data linked to goals, and standardisation. They are highly inter-linked.

The Northern Ireland care system is not seeing the wood for the trees on these ingredients. The *Quality 2020* strategy cites them (and does set some big goals), but they are not held as central and are therefore somewhat lost. They need to be given far more prominence, because they form the bedrock on which all quality and safety improvement is built.

With focused effort, Northern Ireland could: build a cadre of skilled clinical leaders; develop a culture in which quality improvement is second nature; set big goals; establish the information technology systems required to measure quality locally and in real-time; and standardise processes substantially. If the care system makes these activities central to its quality and safety efforts, improvement will follow and will flourish. Without building this bedrock, no other efforts to improve quality and safety will gain any significant purchase.

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4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

Most patient safety programmes have at their core a process to capture and analyse errors and accidents that arise during the provision of care. This is based on the long-established premise that only by learning from things that go wrong can similar events be prevented in the future. To some extent, this draws on the experience of other industries that have successfully reduced accidents and risk year-on-year. This thinking has led to the establishment of incident reporting systems in health services across the world, some operating only at the level of healthcare organisations, some encompassing whole countries and some restricting reports to those within one field of medicine (e.g. surgery).

It is not always appreciated that reporting of incidents (which can be voluntary or mandatory) is only one way of assessing harm in the care of patients. Numerous other approaches have been used, including: prospective observation of care processes; trigger tools involving retrospective case note review; expert case note review; Hospital Standardised Mortality Ratios (and similar metrics); and mining electronic hospital databases.

Alongside Northern Ireland's incident reporting systems runs a complaints system. Globally, surveys have consistently shown that what patients want from a complaints system are: an explanation, an apology, and a reassurance that improvements to the service will be made based on their experience. Other jurisdictions have found that the features of a good complaints system are: satisfactory local resolution of the majority of complaints; speedy response times; excellent communication with patients; good record keeping; apologies made in-person by the senior staff involved not on their behalf; accurate monitoring of the numbers and categories of complaint; effective learning at the local and systemic level.

All these systems have a common primary purpose: to improve the quality of care, and to reduce avoidable harm.

4.4.1 Incident reporting elsewhere

Globally, incident reporting systems vary greatly in: the nature of the data captured, the extent of public release of information, whether reporting is voluntary or mandatory, and the depth of investigation undertaken.

Most reporting systems start by defining in general terms what should be reported. Terminology varies; *adverse event, incident, error, untoward incident* are all in common use internationally. The epithet serious can be applied to any of the terms. The largest national system in the world was established in the NHS in England and Wales as a result of the report *An Organisation with a Memory*. From 2004 until recently, it was run by an independent body, the National Patient Safety Agency, and is called the National Reporting and Learning System. NHS staff are encouraged to make an incident report of any situation in which they believe that a patient's safety was compromised.

In this system, a *"patient safety incident"* is defined as *"any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care."* Reports are first made to a local NHS organisation and then sent in batch returns by the local risk manager to the national level. Staff make a small number of reports electronically directly to the National Reporting and Learning System. The information required covers: demographic and administrative data; the circumstances of occurrence; a categorisation of causation; an assessment of the degree of harm as "no", "low", "moderate", "severe", or "death"; and action taken or planned to investigate or prevent a recurrence. These data are captured in a structured reporting form, but there is also a section of free text where the reporter is asked to describe

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what happened and why they think it happened. Data are anonymised to remove the names of patients and staff members.

In just over a decade, covering the NHS in England and Wales, nearly 10 million patient safety incidents have accumulated in this database. Since 2012, it has been mandatory to report all cases of severe harm or death. It remains voluntary to report all other levels of harm.

During the period of its existence, the National Patient Safety Agency in England and Wales issued 77 alerts and many other notices about specific risks, most of which had been identified by analysis of patient safety incident reports. New arrangements for issuing alerts are in place following the abolition of the National Patient Safety Agency.

This system of incident reporting in England and Wales holds a huge amount of data but only a small proportion of it is effectively used. It is currently being reviewed and is unlikely to continue in exactly the same way.

Worldwide, the problems associated with incident reporting are remarkably consistent, whatever system design is adopted. Firstly, under-reporting is the norm, although its degree varies. This seems to depend on the prevailing culture and whether incidents are seen as an opportunity to learn or as a basis for enforcing individual accountability and apportioning blame. It also depends on staff perceptions about the difference their report will make and how easy it is for them to convey the information that they are required to. Reporting rates are much lower in primary care services than in hospitals. Secondly, given the volume of reports made, there is often insufficient time, resource and expertise to carry out the depth of analysis required to fully understand why the incident happened. Thirdly, the balance of activity within reporting systems goes on collecting, storing, and analysing data at the expense of using it for successful learning. Indeed, there are relatively few examples worldwide of major and sustained reductions in error and harm resulting because of lessons learnt from reporting.

4.4.2 Incident reporting in Northern Ireland

Incident reporting began in the Northern Ireland health and social care system in 2004. Two categories of incident were established: *an adverse incident and a serious adverse incident.* The former were reported and investigated locally within each Trust. The latter were documented and investigated locally but also had to be reported to the Department of Health, Social Services and Public Safety. Staff make 80,000 to 90,000 adverse incident reports each year. Over 400 Serious Adverse Incident reports were made in 2013. In the five-year period from 2009, the number of Serious Adverse Incidents related to Emergency Departments rose from 8 to 36.

An adverse incident is defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

In 2010, major new guidance was issued passing responsibility for managing and further developing the serious adverse incident system to the Health and Social Care Board, where it remains to this day. Further guidance was issued in 2013 with new reporting rules.

To be regarded as a Serious Adverse Incident for reporting purposes, the incident must fall into one of the following categories: the serious injury or unexpected/unexplained death of a service user, staff member or visitor; the death of a child in health or social care; an unexpected serious risk to a service user and/or staff member and/or member of the public; an unexpected or significant threat to service delivery or business continuity; serious

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

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self-harm or assault by a service user, staff member, or member of the public within a healthcare facility; serious self-harm or serious assault by any person in the community who has a mental illness or disorder and is in receipt of mental health and/or learning disability services, or has been within the last twelve months; and, any serious incident of public interest.

Any staff member may report an adverse incident. The reporter is not asked to make a judgment about whether the incident meets the serious adverse incident criteria. A responsible manager makes it based on their reading of the incident and application of the guidelines. Any Serious Adverse Incident must be reported to the Health and Social Care Board within 72 hours. A subset of Serious Adverse Incidents must be simultaneously reported to the Health and Social Care Board and the Regulation and Quality Improvement Authority.

Trusts in Northern Ireland differ slightly in the procedure adopted for encouraging, receiving and investigating incident reports. Generally, all staff are encouraged to make reports as a way of making care safer. They complete an incident report and submit it to the Trust's risk management department so that it can be entered into the risk management database. Increasingly, more reports are being made on-line which cuts out the laborious form-filling which is an undoubted barrier to staff making a report and often leads to paper mountains in the risk management department. Trusts vary in the proportion of incidents that they investigate, the depth of that investigation and the extent to which action is agreed and implemented. Clinical governance committees (or their equivalents), sub-committees of the Trust board or the Board itself usually look at a selection of individual incident reports, at aggregated incident data or at both.

The number of Serious Adverse Incidents varies between Trusts (Figure 1). To some extent this reflects their differing number of patients. However, there is no way of knowing at present whether a higher level of incidents means that the organisation is less safe than others or that it is more safe and that its staff are more conscientious in making reports so that learning can improve patient safety. Whilst data are available on Serious Adverse Incident types, the categories and classifications used do not make it easy to aggregate data in a way that enables systemic weaknesses to be identified. Opportunities are therefore being lost for surveillance of patient safety across Northern Ireland.

The vast majority of Serious Adverse Incidents are reported by the five acute Trusts. Much smaller numbers are reported by the ambulance service and by primary care (Figure 2). The number of incidents reported has increased quite substantially from 2013 to 2014 (Figure 3). In part this is because of improved awareness of the reporting system. In part it is because the reporting criteria were changed – most notably, requiring that all child deaths be reported.

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Figure 1. Serious Adverse Incident reports: by Trust

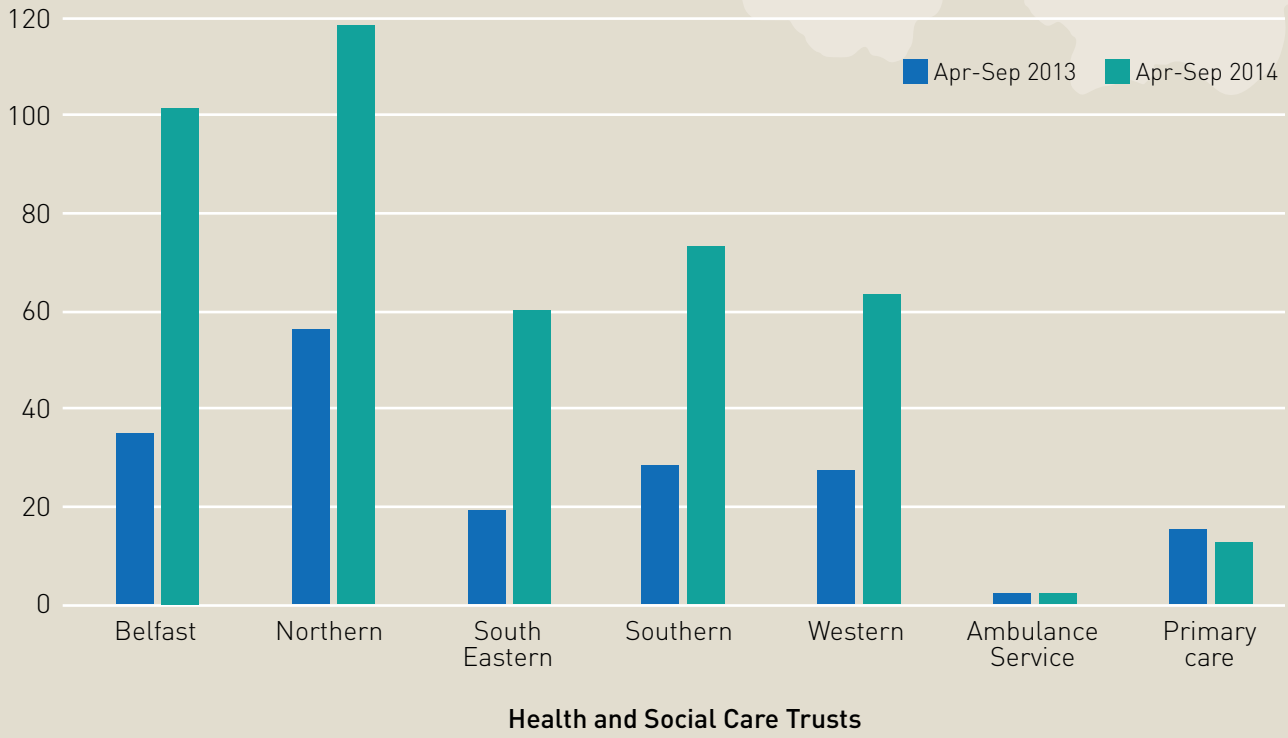
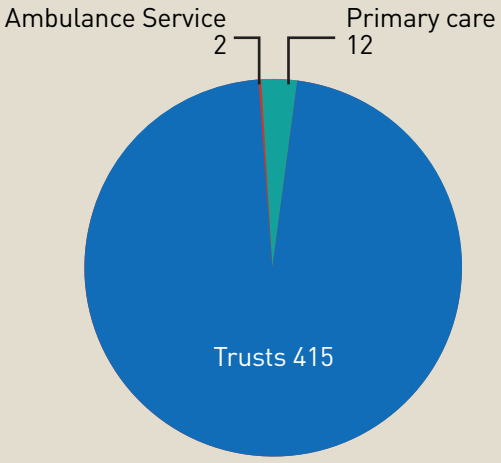
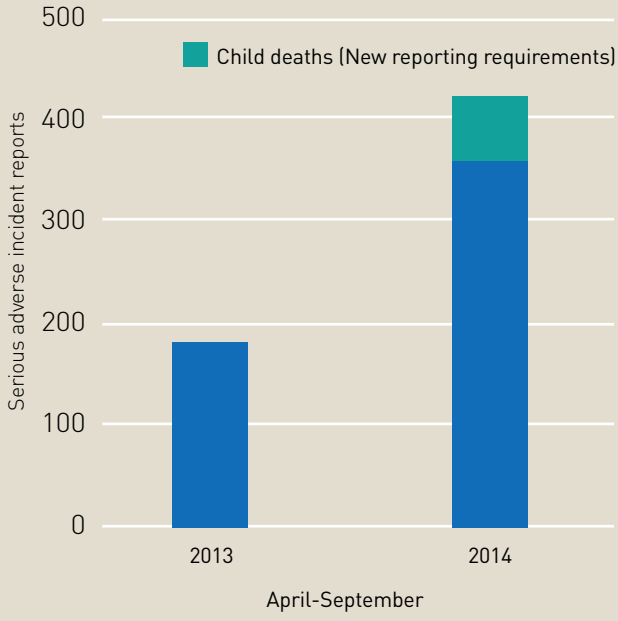


Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts



Serious Adverse Incident Reports, Apr-Sept 2014

Figure 3. Serious Adverse Incident reporting increased between 2013 and 2014. Some of the increase was because reporting criteria changed, particularly introducing a requirement to report all child deaths.



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All Serious Adverse Incidents are investigated. The type (and therefore intensity) of the investigation should depend on the severity of the incident, its complexity, and the potential to learn from it. Three levels of investigation are stipulated:

- *Level 1* involves a Significant Event Audit – a method of assessing what has happened and why, agreeing follow-up actions, and identifying learning.

- *Level 2* involves a Root Cause Analysis – a more detailed exercise to determine causation and learning, undertaken by a formal investigation team chaired by somebody not involved in the incident.

- *Level 3* involves a full-blown independent investigation.

Most Serious Adverse Incidents start at Level 1 investigation, and may proceed to Level 2 or 3 if the Level 1 investigation suggests that this is necessary or would be useful. A minority start at Level 2 or 3 immediately, bypassing Level 1.

A Designated Review Officer, assigned by the Health and Social Care Board and Public Health Agency, provides independent assurance that an appropriate level of investigation has been chosen, and that it is conducted appropriately.

The process of dealing with Serious Adverse Incidents at the operational level of the service is very involved and highly regulated with little room for flexibility. There are a number of decision-making points at which important judgments must be made by staff on matters such as what level the incident falls into and whether to refer an incident to the coroner.

4.4.3 Frustrations with the incident reporting system

The staff who use the incident reporting system have concerns and frustrations. Firstly, at the policy level, the requirements to report Serious Adverse Incidents places a considerable burden on them to complete forms and meet deadlines, with very little flexibility to deviate from the proscribed procedure. There is an acceptance by staff that it is important to document and investigate Serious Adverse Incidents but the pressure to complete all the steps of the process often means that there is no time to reflect on what can be learned so as to reduce risk for future patients. One of the Serious Adverse Incidents that the Review Team discussed with Trust staff had involved interviews with 34 different people. It was by no means the most complex incident that the Review Team heard about.

There is an almost universal view that the requirement to report and investigate all child deaths in hospital as Serious Adverse Incidents has been a retrograde and damaging policy decision. The consequence of it has been that, if a child dies from a cause such as terminal cancer or a congenital abnormality, a grieving family must be advised that there is to be an investigation. Inevitably, this strongly implies that the service has been at fault. Such an approach is not kind to such families, puts staff in a very difficult position, and diverts attention from the investigation of genuinely avoidable incidents involving the care of children. In a separate aspect of incident policy, many staff working within the mental health field have concerns about the inflexibility of the Serious Adverse Incident scheme as it applies to suicide of their patients. Whilst the time-scales for investigation impose a necessary discipline on the process generally, the range of factors, individuals and agencies that need to be part of the determination of the root causes of the suicide of a mental health patient are very great indeed. The pressure to adhere to statutory deadlines can mean that the work in such cases can sometimes be incomplete and so has limited value in preventing recurrences.

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Secondly, at the cultural level, some medical, nursing and social care staff are concerned that, in reporting an adverse incident, they will expose themselves to blame and possible disciplinary action. Junior doctors told the Review Team that making too many reports draws suspicion that they are trouble-makers and that an active interest in patient safety could damage their career prospects. They prefer to make their views on patient safety known through the medical trainee annual survey (Figure 4), where they can remain anonymous.

Figure 4. Percentage of medical trainees reporting concerns about patient safety and the clinical environment

Trust:	Belfast	Northern	South Eastern	Southern	Western
Patient safety	6.5%	6.8%	3.0%	4.7%	3.2%
Clinical environment	2.8%	3.6%	0.8%	1.4%	0.4%
Total	9.3%	10.4%	3.8%	6.0%	3.7%

Source: General Medical Council National Training Survey 2013. Numbers are rounded.

These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them.

Thirdly, at the operational level, staff frustrations with the incident reporting processes range from the very practical, such as not being able to find the form necessary to make the report, to the deeper de-motivating features of the system such as never receiving any feedback or information on the outcome of the report that they had made. Other weaknesses of the process perceived by staff include: having little training in how to investigate properly, reporting an incident then being asked to investigate it yourself, and a tendency for investigations to descend into silos even though there might have been a multi-specialty element to the patient's care.

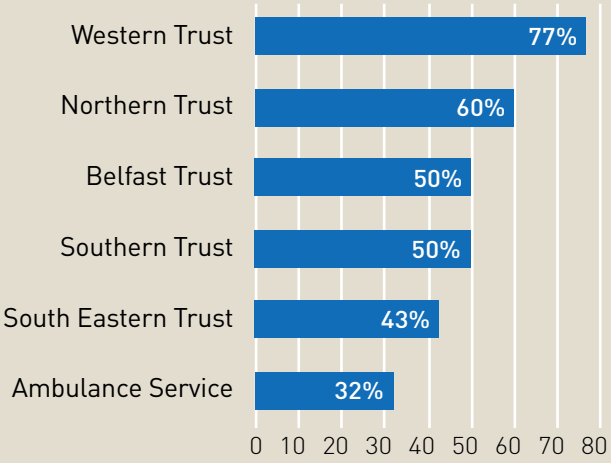
4.4.4 The complaints system in Northern Ireland

Patients, their carers, and their families can make a complaint about the services received in person, by telephone or in writing. If the complaint concerns the health or social care services delivered by one of the six Trusts in Northern Ireland, a senior officer within the organisation will work with the staff involved in the person's care to investigate and produce a response. A letter from the chief executive officer of the Trust must go to the complainant within 20 working days. However, performance is suboptimal and very variable in this respect (figure 5).

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

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Figure 5. All Trusts are failing to meet the standard 20-day substantive response time for complaints (% meeting standard shown; 2013-14)



The best outcome is for the complaint to be resolved locally to the complainant's complete satisfaction. This is not always possible and if the complainant is not satisfied with the response, the complaint can be re-opened and further investigation can be undertaken or external advice sought. If this still does not resolve the complaint, the complainant can make a submission to the Ombudsman. He will look at whether the process of responding to the complaint was undertaken appropriately. He can also investigate the substance of the complaint but under present legislation, he cannot make these reports public. This bizarre situation means that the public is unaware of where standards have fallen short and what the Ombudsman thinks should be done.

An increasing number of people who have complaints contact The Patient and Client Council asking for help. The Council does not have powers to investigate complaints, only to provide support. Nearly 2000 complainants contacted the Council last year. Many such contacts were from people who had tried to navigate the complaints system alone and had had difficulties. The Patient and Client Council's involvement often helps in facilitating resolution of the complaint, sometimes by arranging meetings of the two sides.

Complaints about primary care are handled somewhat differently. They are raised with the Health and Social Care Board directly. The number of complaints from primary care is lower than might be expected. This may reflect the reluctance of patients to complain about a service that they are totally reliant on.

4.4.5 Involvement of the coroner

Northern Ireland, like elsewhere, is still grappling with a difficult question: what is the appropriate role for the Coroner in the investigation of deaths that may have been caused, at least in part, by patient safety problems? This is not an easy question. It is difficult to create guidance that precisely defines which deaths should be investigated by the coroner and which should not. And Coroner's inquests have major pros and cons.

When somebody dies and their care may have been perceived as poor, some families call for a Coroner's inquest. The positive elements of this are that the Coroner is independent of the health and social care system, has clear legal powers, and is skilled in the investigation of deaths.

On the other hand, conducting an inquest into every Serious Adverse Incident that results in a death would be a resource-intensive undertaking. It also may not result in the most effective learning. Few could honestly say that the courtroom environment does not intimidate them. It is not the easiest place to build a constructive relationship between the clinicians involved in the care of the deceased and the deceased's family. It is not the most conducive environment to open, reflective learning.

In cases of negligence or gross breaches of standards of care, it is very clear that referral to the Coroner is the most appropriate course.

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At the other end of the spectrum, in a few cases there is a Serious Adverse Incident at some point during a patient's care and this patient subsequently dies, but the death is entirely unrelated to the incident and so an inquest is really not warranted. In between these two extremes lies a substantial grey area, in which the relative merits of a Coroner's inquest and an internal Serious Adverse Incident investigation are debatable. This is not only the case in Northern Ireland, but across the United Kingdom as a whole (except that Scotland does not have a Coroner).

This is a complex issue. Currently only a subset of the deaths that could be the subject of a Coroner's inquest actually become so. Some are not reported to the coroner's office (largely appropriately, it seems) and some are discussed with the coroner's office but not listed for inquest. In other words, the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.

To some this may sound shocking but, given the complexity of the issues involved, the status quo is not entirely unreasonable and is in line with practice internationally. But the status quo is certainly not ideal. There is substantial room for improvement, so that the coroner can more optimally contribute to the system's learning.

4.4.6 Redress

The creation of financial, and other new, forms of redress would have to be linked to the handling of complaints, incidents and medical negligence claims in a whole systems manner. This is a highly complex area that was extensively examined in England in the report *Making Amends*. In the end, the central idea of introducing some payments for victims of harm and recipients of poor quality care, as well as potential litigants, was not taken forward. There were sound principles behind the proposals, but there was a leap-in-the-dark element too. Priority was given instead to action to improve the quality and safety of care and to improve responses to complaints. However, one of the other proposals of *Making Amends*, the introduction of a Duty of Candour, is finally being implemented in England. The Review Team considers that priority in Northern Ireland should be given to the areas covered by its recommendations, to making important changes to generate safer higher quality care, rather than embarking on new policies for redress, including financial compensation.

4.4.7 The nature of learning

The whole question of how *learning* takes place in healthcare through the scrutiny and analysis of incident reports or through their investigation has been little debated. Indeed, the term learning itself is very loosely applied in this context. Strictly applied, it would mean acquiring new knowledge from incidents about how harm happens. Yet, the way in which the word learning is repeatedly used in the context of patient safety is more than increasing understanding. It implies that behaviour will change or actions will be taken to prevent future harm. Unfortunately, although there are some exceptions, there is little evidence that major gains in the reduction of harm have been achieved in Northern Ireland or in many other jurisdictions through the so-called learning component of patient safety programmes.

In Northern Ireland, the main formally-identified processes for reducing risk or improving patient safety, aside from action plans derived at Trust level, are:

- the production of learning letters
- the bi-annual Serious Adverse Incident Learning Report
- the circulation of newsletters such as *Learning Matters*
- thematic reviews
- training and learning events

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- implementing the recommendations of reviews and inquiries
- disseminating alerts and guidance imported from other parts of the United Kingdom or further afield.

On many, perhaps most, occasions when something goes wrong, the potential for learning from this is very rich indeed. This potential too often goes unrealised. This is a problem not just in Northern Ireland, but in care systems worldwide.

Three features determine the extent to which investigation of an adverse event results in risk being reduced:

- How deep the investigation gets, in understanding the true systemic issues that helped something go wrong
- How systemic the investigation's focus is, in considering where else a similar problem could have occurred beyond the local context in which it did occur
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat

The first of these, depth of investigation, is done reasonably well. A decade ago, harm was often put down to 'human error'. There is now far greater recognition that this is a superficial interpretation – that there are almost always problems within the system which not only allowed that harm to occur but made it more likely. The technique of root cause analysis is widely used in Northern Ireland, and helps to uncover some of the causal elements. Often, though, it does not find the deeper reasons. This is partly because of the time pressures to finish the investigation, partly because not all staff have had the necessary training to do this deeper analysis, and partly because of a lack of human factors expertise in the process. Also, many hospital incidents involve primary care in the chain of possible causation, yet primary care staff play a minor, or no, role in many investigations.

In relation to the systemic view, when a problem occurs, there is too great a tendency to investigate that specific problem, without looking for the broader systemic issues that it highlights. Problems are often addressed in the department where they occur, without asking whether they could have occurred in other departments, for example. Similarly, if a medication incident occurs, there is a tendency to fix the problem for that medication, without looking at whether there is a problem for similar medication or routes of administration.

This narrow, reactive approach fails to make full use of incident reports. In short, it reflects an erroneous assumption that the system as a whole is working fine, and that the problems that allowed the event to occur are specific, local ones. This is not the case. There are systemic problems through the health and social care system. Incidents of harm are distributed largely by chance – by location and by type. Fixing each specific problem is like playing "Whack-A-Mole" – it does not get to the nub of the issues.

The ultimate aim of investigation is to reduce the risk of harm, not simply to understand what went wrong. Corrective action is too often inadequate. There is no automatic link between understanding what went wrong and being able to reduce the risk of it happening again. Indeed, making the leap between investigation and risk reduction is really very challenging.

In Northern Ireland, the action lists that are generated by Serious Adverse Incident investigation commonly feature plans of the following kinds:

- Making staff aware that the incident took place
- Explaining to staff what went wrong
- Circulating a written description of the incident and actions taken to other parts of the health and social care system to share the learning

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Such information sharing actions should form part of the plan but they do not amount to systemic measures that will reliably and significantly reduce the risk to patients.

Research and experience outside health care has shown that safety comes down to appreciating that big improvements are not made by telling people to take care but by understanding the conditions that provoke error.

Action plans often also feature some change to current paperwork or introduction of new documentation. This, too, is very reasonable but often has a weak impact on outcomes. It also has the important downside that mounting paperwork reduces the time for patient care and introduces complications of its own.

So what do strong corrective actions look like? Technological solutions have an important role to play. Electronic prescribing systems, patient monitoring systems, and shared care records can address multiple patient safety issues simultaneously (although their implementation and use is not without risk). Policies, rules, and checklists can also be useful, but are easy to implement badly and more difficult to implement well.

As discussed earlier in this Report, one area of high potential is the use of standardisation of procedure. It is underutilised in healthcare worldwide but where it is applied it has brought results. Standardisation of procedure is a mainstay of safety assurance and improvement in other sectors.

In large part, though, healthcare systems worldwide are not yet good at implementing solutions that will truly reduce risk. It is not the case that Northern Ireland is lagging behind – but that Northern Ireland is struggling with this problem alongside other countries.

Identifying the systemic issues and identifying strong corrective actions: each of these is tough; an art and a science in itself; an area in need of intense and rigorous study. Until these issues are tackled head on, in Northern Ireland and elsewhere, the system's learning when things go wrong will fall short.

When something goes wrong, patients and families ask for reassurance that it will not happen again. As it stands, nobody can honestly provide this reassurance. In fact, it is difficult even to say that the risk has been significantly reduced – let alone to zero. This needs to change.

4.4.8 Strengths and weaknesses of Northern Ireland's systems for incident reporting and learning

No system of reporting and analysing patient safety incidents is perfect. In an ideal world, all events and occurrences in a health service that caused harm or had the potential to cause harm would be quickly recognised by alert, knowledgeable front-line staff who would carefully document and communicate their concern. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports improved the safety of care. The resulting investigation would be impartial and multi-disciplinary, involving expertise from relevant clinical specialties but, crucially, also from other non-health disciplines that successfully contribute to accident reduction in other fields of safety. Investigation would be carried out in an atmosphere of trust where blame and retribution were absent, and disciplinary action or criminal sanctions would only be taken in appropriate and rare circumstances. Action resulting from investigation would lead to re-design of processes of care, products, procedures and changes to the working practices and styles of individuals and teams. Such actions would usually lead to measurable and sustained reduction of risk for future patients. Some types of harm would be eliminated entirely.

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Very few, if any, health services in the world could come anywhere near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons ranging from an insufficiency of leaders skilled and passionate enough to engage their whole workforces on a quest to make care safer, through an inability to investigate properly the volume of reports generated, to the weak evidence-base on how to reduce harm.

The system of adverse incident reporting in Northern Ireland operates to highly-specified processes to which providers of health and social care must adhere. The main emphasis is on the Serious Adverse Incidents. The requirements laid down for reporting, documenting and investigating such incidents together with the rules for communicating about them and formulating action plans to prevent recurrence have created an approach that has strengths and weaknesses (Figure 6). In general, the mandatory nature of reporting means that there is likely to be less under-reporting than in many other jurisdictions. However, staff in Trusts must exercise judgment on whether to classify occurrences of harm as Serious Adverse Incidents. Whether they always make the right decision has not been formally evaluated. The Review did not find any evidence of suppression or cover-up of cases of serious harm.

Figure 6. Serious Adverse Incident reporting system in Northern Ireland: Strengths and weaknesses

Dimension	Strengths	Weaknesses
Accountability	Absolute requirement to report and investigate	Creates some fear and defensiveness
Coverage	Relatively high for serious outcomes	Less attention given to incidents with lower harm levels
Timescales	Clear deadlines for investigation and communication	Pressure to meet deadlines leaves little time for reflection
Investigation	Reasonable depth with frequent root cause analysis	Quality variable and little use of human factors expertise
Staff engagement	All appear to understand the importance of reporting	Do not often see the reports translating into safer care
Patient and family involvement	Requirement to communicate reinforced by checklist	Often creates tension and little ongoing engagement
Learning	Specified action plan required in every case	Not clear whether action is effective in reducing future risk

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Tight time-scales are laid down for the various stages of handling a Serious Adverse Incident. These generally add a necessary discipline to a process that in other places can become protracted or drift off-track. There is a need, though, for some flexibility where an investigation requires more time. This is particularly so in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing very many people.

It is important to recognise that, whilst almost all of the experience and research literature is about patient safety, Northern Ireland has an integrated health and social care system. Social care in the United Kingdom has its own traditions in recognising, investigating and learning from episodes of serious harm involving those who use its services; the fields of child protection and mental health exemplify this. It is not entirely straightforward to integrate incidents in social care into the overall patient safety approach but the essential principles and concepts are little different.

The Northern Ireland health service falls short of the ideal just as do most other parts of the United Kingdom and many other places in the world. In all of these places, including Northern Ireland, patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high-risk industry.

The Northern Ireland approach to incident reporting and learning does not make its services any less safe than most of the rest of the United Kingdom or many other parts of the world. However, this should not be a reason for comfort, nor a cause for satisfaction.

The current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing far more harm than good. It is distressing for families, burdensome for staff, and is not producing useful learning.

The ethos of improving safety by learning from incident investigations needs to shift:

- Away from actions that only make a difference in the particular unit where the incident occurred, towards actions that also make a difference across the whole of Northern Ireland
- Away from actions that only target that particular incident, towards actions that also reduce the risk of many related incidents occurring
- Away from weak actions such as informing staff, training staff and updating policies, towards stronger actions of improving systems and processes
- Away from long lists of actions, towards smaller numbers of high-impact actions

Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident. They are reported, analysed and acted upon at Trust level. Only exceptionally are they considered centrally. The numbers are much greater so the logistics of analysing more would be considerable. However, there is much to be learned from situations when something went wrong in a patient's care but they did not die or suffer serious harm.

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4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

The health and social care system aspires to a 'no blame' culture, or a 'just' culture, in which staff can be open without fear of inappropriate reprisal. In reality, this is not the culture that currently exists. This is not primarily the fault of those delivering health and social care.

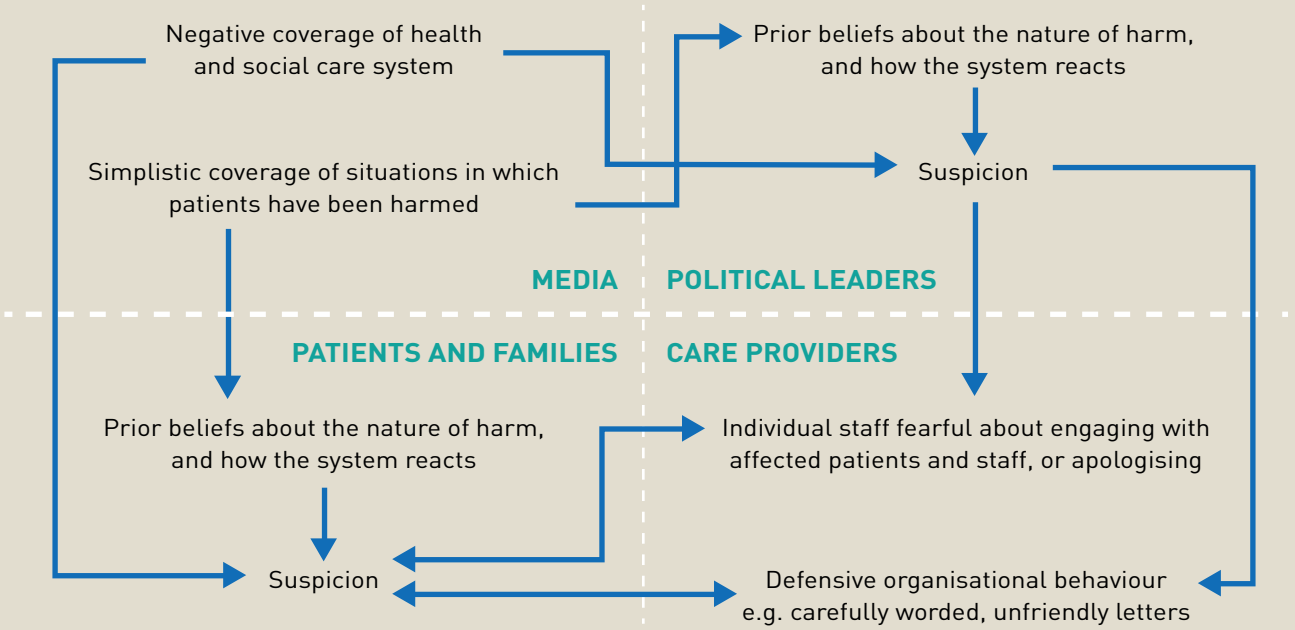
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

When something goes wrong, many patients' and families' first reaction is to want to know who is to blame. The situation often escalates, with the media coverage and political pressure that the detail of the story generates. In an ideal world, leaders of the system should be able to step in to paint a proper picture of the background to these complex events, and to build public understanding that few are a simple case of incompetence and carelessness. Instead, to remove the heat from the situation, approaches are announced that may not be the most effective way to achieve learning. On top of this, day-by-day the media portrays health and social care in a mainly negative light. There has been one inquiry after another. These are conditions conducive to blame and fear, not to transparency and openness.

Despite these adverse conditions, the Review Team found front-line staff willing to talk about problems, and to be open with families and patients when things go wrong. There is a willingness to be open – but there is blame, and there is fear.

Northern Ireland needs to increase the degree of openness and transparency in talking about harm, and decrease the degree of blame and fear. The responsibility cannot lie solely within the health and social care system. They are complex cycles.

Figure 7. The vicious cycle of suspicion and fear



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Openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this Report has made clear, Northern Ireland is far from unique.

4.5.1 Governance arrangements to promote openness

Promoting openness and avoiding fear is about culture. Responsibility for this sits with many people, within and beyond the health and social care system. Governance may sound like a blunt tool and, used alone, it would be. But alongside other approaches, appropriate governance arrangements can promote openness and dispel fear.

The Serious Adverse Incident process currently requires Trusts to inform affected patients (or families) that their care is the subject of investigation. In general, they are invited to provide input and are provided with a copy of the investigation report. A checklist has been introduced to prompt investigators to take these steps. This is commendable, and represents a basic, but important, degree of openness with patients and families.

The nature of the involvement with patients and families in the aftermath of a Serious Adverse Incident cannot be shaped by a checklist alone. The Review Team heard from each of the Trusts how they handled this aspect of the policy. It is clear that this is a difficult area to get right. Early contact with the family in the event of a death is important but could come at a time when funeral arrangements are being made and perceived as intrusive or insensitive. The bureaucracy of the procedure can create an official feeling that opens up distance in the relationship with the family. It is important that staff in the Trust have the skill, experience and credibility to communicate with a family. It is helpful to have staff who deal with this situation regularly and have good inter-personal and counselling skills. They should be there with the clinical staff who may encounter the situation less frequently. Experience from elsewhere suggests that regular contact with the patient and family is important, not just a couple of one-off meetings with long silences in between. In the best services, the patient and family are fully involved in the process of learning and action-planning. Where this happens, it is empowering for everyone. This is only happening to a limited extent in Northern Ireland currently.

The Serious Adverse Incident process is also overseen by a Designated Review Officer within the Public Health Agency. This is also a welcome feature of the system although there is potential for these officers, or their function, to play a more substantial role.

Every Trust has appropriate arrangements for Serious Adverse Incidents to be discussed within the departments affected. The fact that these conversations are taking place usefully promotes a culture in which talking about harm becomes easier, and openness becomes the norm.

Every Trust also has arrangements for organisation-level oversight of this process. In most, this responsibility sits with a sub-committee of the Trust board. This too is good practice.

When something goes wrong, there is a tendency for the Department of Health, Social Services and Public Safety to deal directly with the Trust's Executive Team, bypassing the board. This happens partly from expediency – because the executive directors are present full-time, and are therefore available to take an urgent phone call from an official concerned about briefing the minister. But it serves to diminish the role of the board, and misses opportunities to build the board's familiarity with these issues and capability in dealing with them.

There is great concern and depth of feeling amongst staff in the system who have attempted to uncover poor standards of

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care and been denigrated. Their role as whistleblowers has placed them in an even more isolated position. This unsatisfactory situation needs to be resolved.

4.5.2 Perceptions of openness

The Serious Adverse Incident guidelines include some requirements intended to help openness and transparency. A recent look-back exercise, quality controlled by the Regulation and Quality Improvement Authority, suggests that patients and families are being appropriately informed when a Serious Adverse Incident occurs. This creates a substantially higher degree of openness than is the case in many countries worldwide. In the main, the Trust staff who are leading the investigation are willing to spend time meeting with patients and families.

However, several features of the investigation process too often give patients and families an adverse impression:

- The investigation process is frequently delayed beyond the stipulated timeline, and patients and families experience delays in getting responses to calls and emails. Such delays make people start to wonder, "what is going on?"
- When the investigation process starts, the degree of openness and transparency that the patient and/or family feel they are seeing is highly dependent on the communication skills of the Trust staff that they meet with. Some staff are highly skilled in these potentially difficult meetings; others are not.
- Standard practice is for patients and families to meet with the manager and/or clinician leading the investigation, and not to be asked whom else they would like to meet with. Many, for example, would find it helpful to meet with the staff directly involved in the incident, to put their questions directly, but this is not routinely offered. Such meetings have the potential to be intensely difficult; to be very useful if they go well, but harmful if they go badly.

4.5.3 Duty of candour

In 2003, the head of the Review Team (as Chief Medical Officer for England) issued a consultation paper, *Making Amends*, which set out proposals for reforming the approach to clinical negligence in the NHS. One key recommendation was that a duty of candour should be introduced.

As long ago as 1987 Sir John Donaldson (no relation), who was then Master of the Rolls, said "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man". There was, at the time of the *Making Amends* report, no binding decision of the courts on whether such a duty exists.

In November 2014, the General Medical Council and the Nursing & Midwifery Council issued a joint consultation document proposing the introduction of a professional duty of candour. Such a duty will give statutory force to the General Medical Council's Code of Good Medical Practice for doctors.

In the concomitant healthcare organisational measures introduced in England, a new "Duty of Candour" scheme will mean that hospitals are required to disclose information about incidents that caused harm to patients, and to provide an apology.

In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators.

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4.6 THE VOICES OF PATIENTS, CLIENTS AND FAMILIES ARE TOO MUTED

The best services in the world today give major priority to involving patients and families across the whole range of their activities, from board-level policy making, to design of care processes, to quality improvement efforts, to evaluation of services, to working on reducing risk to patients as part of patient safety programmes.

At the heart of the traditional approach to assessing whether a service is responsive to its patients and the public are surveys of patient experience and attitudes. This is still a very important part of modern health and social care. In many major centres whose services are highly rated, such surveys are regularly carried out and used to judge performance at the organisational, service and individual practitioner level, as well as, in some cases, being linked to financial incentives. Indeed, in the United States system, observers say that it was not until surveys of patient experience were linked to dollars that it was taken seriously. This is not a prominent feature of the Northern Ireland system, although there is some very good practice, for example the 10,000 Voices initiative, which has so far drawn on the experience of over 6,000 patients and led to new pathways of care in pain management, caring for children in Emergency Departments, and generally focusing on the areas of dignity and respect.

Looked at from first principles, the kind of questions a user, or potential user, of a service could legitimately require an answer to would include:

How quickly will I first be seen, how quickly will I get a diagnosis and how quickly will I receive definitive treatment?

If my condition is potentially life-threatening, will the local service give me the best odds of survival or could I do better elsewhere?

Will each member of staff I encounter be competent and up-to-date in treating my condition and how will I know that they are?

Does the service have a low level of complications for treatment like mine compared to other services?

How likely am I to be harmed by the care that I receive and what measures does the service take to prevent it?

If I am unhappy with a care-provider's response to a complaint about my care, will the substance of it be looked at by people who are genuinely independent?

Which particular service elsewhere in the United Kingdom, and other parts of the world, achieves the best outcome for someone like me with my condition? How close will my outcome be to that gold standard?

Very few of these questions could be answered reliably in Northern Ireland and other parts of the United Kingdom.

There are many potential themes for patient and family engagement in health and social care, for example:

- in shaping and designing services
- in measuring the quality of care
- in setting standards for consultation
- in shared decision-making
- in self-care of chronic diseases
- in preventing harm
- in giving feedback on practitioner performance

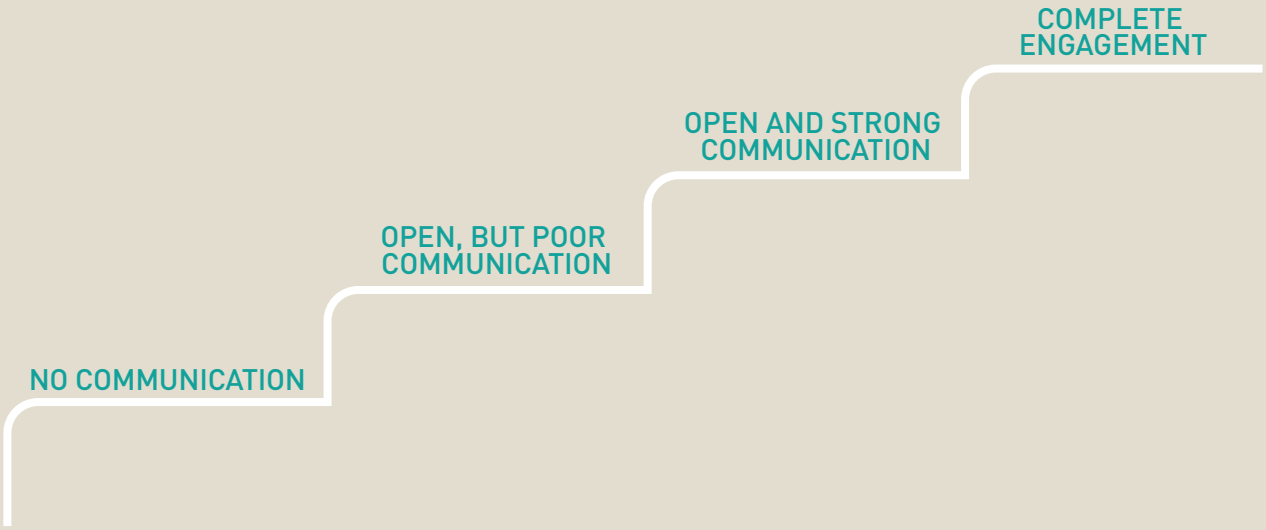
Few services do all of these, some only scratch the surface of genuine involvement, others do a few well. Overall, the Northern Ireland care system is engaged in some of these areas but certainly not in an organised and coherent way.

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The terms of reference of the Review put particlar emphasis on harm. Globally, there is a spectrum in how well health and social care systems interact with patients, clients and families when things go wrong (figure 8). The ideal approach is to engage patients and families completely in the process of learning. They often find this hugely beneficial, because it allows them to play an active part in reducing the risk for future patients. It is also immensely powerful for staff, to hear patients' stories first-hand and to work with them to improve things.

Figure 8. Levels of engagement with patients and families when something goes wrong



Northern Ireland should aim for level three as an absolute minimum, but strive for level four.

The system is too often falling down to level two because:

- Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills – some are excellent, but some are less good. Little formal effort has been made to train staff to manage these difficult interactions well.
- Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead, they tend to meet with managers, and with clinicians who were not involved.
- There are frequently delays in the process of investigating a Serious Adverse Incident.
- Patients and families are too often sent letters filled with technical jargon and legalese.

When something goes wrong, the harm itself is intensely difficult for patients and families. Poor communication compounds this enormously.

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5 CONCLUSIONS

5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

5.1.1 There is some perception amongst politicians, the press and the public that Northern Ireland's health and social care system:

- Has fundamental safety problems that are not seen elsewhere
- Is less safe than other parts of the United Kingdom, or comparable countries
- Suffers from lack of transparency, a tendency to cover-up, and an adverse culture more broadly.

5.1.2 The Review found no evidence of deep-seated problems of this kind. Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally.

5.1.3 This does not mean that safety can be disregarded, because it is clear from reading the incident reports and accounts of patients' experience that people are being harmed by unsafe care in Northern Ireland, as they are elsewhere. Northern Ireland, like every modern health and social care system, must do all it can to make its patients and clients safer.

5.2 PROBLEMS GENERATED BY THE DESIGN OF THE HEALTH AND SOCIAL CARE SYSTEM

5.2.1 There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position.

5.2.2 The design of a system to provide comprehensive, high quality, safe, care to a relatively small population like Northern Ireland's needs much more careful thought. This applies to almost all aspects of design including: the role of commissioning, the structuring of provision, the relationship between primary, secondary and social care, the distribution of facilities geographically, the funding flows, the place of regulation, the monitoring of performance, and the use of incentives. Nowhere is the old adage: "I would not start from here" truer than in the Northern Ireland care system today.

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5.2.3 There is widespread uncertainty about who is in overall charge of the system in Northern Ireland. In statutory terms, the Permanent Secretary in the Department of Health, Social Services and Public Safety is chief executive of the health and social care system but how this role is delivered from a policy-making position is not widely understood or visible enough.

5.2.4 In the specific domain of quality and safety itself, whilst it is reflected in the goals and activities of boards and senior management teams in Northern Ireland, it is not yet fully embedded with the commitment and purpose to make a real difference. The Review was most impressed with the work of the South Eastern Trust in this regard. The Review Team could not assess each Trust in depth, but its judgment on the South Eastern Trust is backed up, for example, by the national survey of trainee doctors.

5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

5.3.1 *Quality 2020* is a ten-year strategy with a bold vision – that the health and social care system should "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care". Three years on, there is good evidence of the strategy being implemented. An influential steering group oversees the work.

5.3.2 The Review Team judged that *Quality 2020* represents a strong set of objectives, and that there is clear evidence of extensive work and of some successes in implementation. However, this does not amount to quality and safety improvement being given the primacy of focus that it needs, and Northern Ireland is not seeing the wood for the trees about the need to establish crucial aspects of quality and safety improvement which are not well represented at present: clinical leadership, cultural change, data linked to goals, and standardisation.

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5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

5.4.1 The system of Serious Adverse Incident reporting in Northern Ireland has been an important way to ensure that the most severe forms of harm that are inadvertently caused by care processes are recognised and investigated.

5.4.2 The Serious Adverse Incident process fulfils five main purposes:

- a public accountability function
- a response to the patients and families involved
- a communications alert route
- a barometer of risk within health and social care
- a foundation for learning and improvement

5.4.3 The kinds of incidents reported into this system appear little different to other parts of the United Kingdom and are similar to many other parts of Europe, North America and Australasia. Many harmful events are potentially avoidable and the human cost to patients and families in Northern Ireland is of grave concern, as it is in other jurisdictions.

5.4.4 Good practice elsewhere in the world suggests that patients who suffer harm and their families should be fully informed about what has happened, how it happened and what will be done to prevent another similar occurrence. More than this, they should be fully engaged in working with the organisation to make change. Patient and family engagement is a good and established feature of Serious Adverse Incident reporting in Northern Ireland but it often falls short of this fully engaged scenario. The extent to which it is valued and trusted by patients and families appears to vary, depending on the staff communicating with them.

5.4.5 The design for the specification, and recording, of information on each Serious Adverse Incident is sub-optimal particularly in gathering appropriate information on causation; this hinders aggregation of data to monitor trends and assess the impact of interventions.

5.4.6 The process for investigating Serious Adverse Incidents is clearly set out and involves root cause analysis-type methods. In many cases, it lacks sufficient depth in key areas such as human factors analysis. The degree of oversight by supervisory officials (the Designated Review Officers) is variable in extent and timeliness. Local health and social care staff generally approach the task of investigation conscientiously but many lack the training and experience to reach a standard of international best practice in unequivocally identifying the cause and specifying the actionable learning. They get little expert help and guidance in undertaking this activity.

5.4.7 The most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it. Unfortunately, there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients. Northern Ireland is no exception to this regrettable state of affairs.

5.4.8 There are two main levels of learning from Serious Adverse Incidents in Northern Ireland. The first is local. The lack of a consistently high standard of investigation and action-planning are barriers to effective risk-reduction within health and social care organisations. Another barrier is the limited degree to which front-line staff are involved in discussing and seeking solutions to things that have gone wrong. Experience elsewhere suggests that this practical and intellectual engagement,

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if well-led, often sparks great interest and commitment to patient safety amongst front-line staff. This is not really happening in Northern Ireland at present, for a number of reasons. Firstly, staff do not have the time and space to do it and the leadership of Trusts is not consistently creating and facilitating such opportunities. The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help. Secondly, the specified rules of the Serious Adverse Incident system mean that Trusts are under a great deal of pressure to meet the time-scales laid down and are often dealing with many such cases simultaneously. As a result, the activity is too often slipping into an incident management role or worse a necessary chore that 'feeds the beast'.

5.4.9 The second level of learning is across the Northern Ireland health and social care system as a whole. The main role is played by the Health and Social Care Board working with the Public Health Agency (and the Regulation and Quality Improvement Authority where appropriate). These bodies have established a multi-disciplinary Quality Safety and Experience Group that undertakes much of the work in assessing patterns, trends and concerns arising from the analysis of locally-generated Serious Adverse Incidents and deciding what action needs to be taken on a Northern Ireland-wide basis. It does so by issuing learning letters, reports, guidance, newsletters and other specified action that the service needs to take. This is a valuable function from which considerable action aimed at improvement has flowed. Experience of improving patient safety elsewhere has shown that specifying action on a particular safety problem is not the same thing as implementing the change required. The latter is often much more difficult and depends on factors such as the systems, culture, attitudes, local priorities and leadership in the organisation receiving the action note. In the Northern Ireland care system more skill needs to be added to the implementation process. This is closely linked to the difficulties that arise when local services feel overloaded with central guidance and requirements for action. They only have enough management and clinical leadership capacity to implement a small number of changes at a time.

5.4.10 General practitioners, and others in primary care, report their Serious Adverse Incidents directly to the Health and Social Care Board, not through any of the Trusts. Levels of reporting of patient safety incidents in primary care services around the world are very low and much less is known about the kinds of harm that arise in this setting compared to hospitals. It is not surprising that the same is so in Northern Ireland. Another aspect of the primary care dimension is that many of the incidents that the Review discussed with the Trusts in Northern Ireland had a primary care element in the key areas of the care processes that had failed, yet general practitioners seemed to be less frequently involved in the investigation and planning of remedial action.

5.4.11 There are two particular aspects of the criteria for Serious Adverse Incident reporting in Northern Ireland that are not working in the best interests of a successful system. Firstly, the requirement that every death of a child in receipt of health and social care should automatically become a Serious Adverse Incident is causing major problems. A proportion of such deaths every month are due to natural causes. Some of the conditions concerned - for example, terminal cancer and serious congenital abnormalities - are particularly harrowing for the parents. After the death of a child, in such circumstances, for a family to be told that their child's death has been categorised as a Serious Adverse Incident carries the clear implication that the quality or safety of care was poor and at fault or even that the death could have been avoided. This can be enormously distressing for families and

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is grueling for staff. It is cruel, unnecessary and liable to undermine public confidence in children's services.

5.4.12 Secondly, using the same time-scales for investigating Serious Adverse Incidents in mental health as in in other fields of care is also causing major problems. The complexity of many mental health cases, the long past history of many such patients and clients, and the number of people and organisations who may be able to contribute relevant information to the investigation mean that a longer period is necessarily required to get to the truth than is currently permitted.

5.4.13 Overall, the system of Serious Adverse Incident reporting in Northern Ireland, in comparison to best practice, scores highly on securing accountability, reasonably highly on the level of reporting, does moderately well on meaningful engagement with patients and families, and is weak in producing effective, sustained reduction in risk. Also, the climate of accountability and intense political and media scrutiny does not sit easily with what best practice has repeatedly shown is the key to making care safer: a climate of learning not judgment.

5.4.14 The Review concluded that front-line clinical staff are insufficiently supported to fulfill the role of assessing and improving the quality and safety of the care that they and their teams provide. The lack of time, the paucity of reliable, well-presented data, the absence of in-service training in quality improvement methods, and the patchiness of clinical leadership are all major barriers to achieving this vital shift to mass clinical engagement.

5.5 OPENNESS WITH PATIENTS AND FAMILIES

5.5.1 The Serious Adverse Incident investigation system contains, in the view of the Review Team, sufficient checks and balances to ensure that affected patients and families are informed that something went wrong, except in exceptional circumstances.

5.5.2 Such mechanisms are part of good governance, but alone are insufficient. It will be culture – not accountability – that increases the reporting of harm, and staff's comfort in talking openly about harm.

5.5.3 Those conducting investigations are committed to rigorous investigation, and to being open with patients and families about what is found. But whilst some communicate well in person and in writing, others are less strong. This can come across to families as a lack of openness.

5.5.4 High-profile inquiries and negative media coverage have led some to believe that there is widespread cover-up of harm in the health and social care system. This is simply inconsistent with what the Review Team observed, which was a system trying, as many others in the world are, to get to grips with the difficult problem of patient safety.

5.5.5 Fear and suspicion powerfully inhibit openness. The health and social care system needs to rise to the challenge of tackling these threats head on. Perception is important – even simple delays and communication weaknesses can fuel suspicion. And if staff hear more from the media than direct from their leaders, this does not dispel fear.

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6 RECOMMENDATIONS

Recommendation 1: Coming together for world-class care

A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.

We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.

Recommendation 2: Strengthened commissioning

The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.

We recommend that the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.

Recommendation 3: Transforming Your Care – action not words

The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.

We recommend that a new costed, timetabled implementation plan for *Transforming Your Care* should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.

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

Recommendation 4: Self-management of chronic disease

Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.

We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.

Recommendation 5: Better regulation

The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission's role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.

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Recommendation 6: Making incident reports really count

The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:

- **deaths of children from natural causes should not be classified as Serious Adverse Incidents;**
- **there should be consultation with those working in the mental health field to make sensible changes to the rules and time-scales for investigating incidents involving the care of mental health patients;**
- **a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);**
- **a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;**
- **a limited list of Never Events should be created**
- **a portal for patients to make incident reports should be created and publicised**
- **other proposed modifications and developments should be considered in the context of Recommendation 7.**

Recommendation 7: A beacon of excellence in patient safety

There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities

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(including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:

- **carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;**
- **improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;**
- **instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;**
- **facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;**
- **bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;**
- **developing valid metrics to monitor progress and compare performance in patient safety;**
- **analysing adverse incidents on a sampling basis to enhance learning from less severe events;**
- **giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;**
- **fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;**
- **creating a cadre of leaders in patient safety across the whole health and social care system;**
- **initiating a major programme to build safety resilience into the health and social care system.**

Recommendation 8: System-wide data and goals

The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.

We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.

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Recommendation 9: Moving to the forefront of new technology

The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the long-standing quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.

We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.

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

Recommendation 10: A much stronger patient voice

In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.

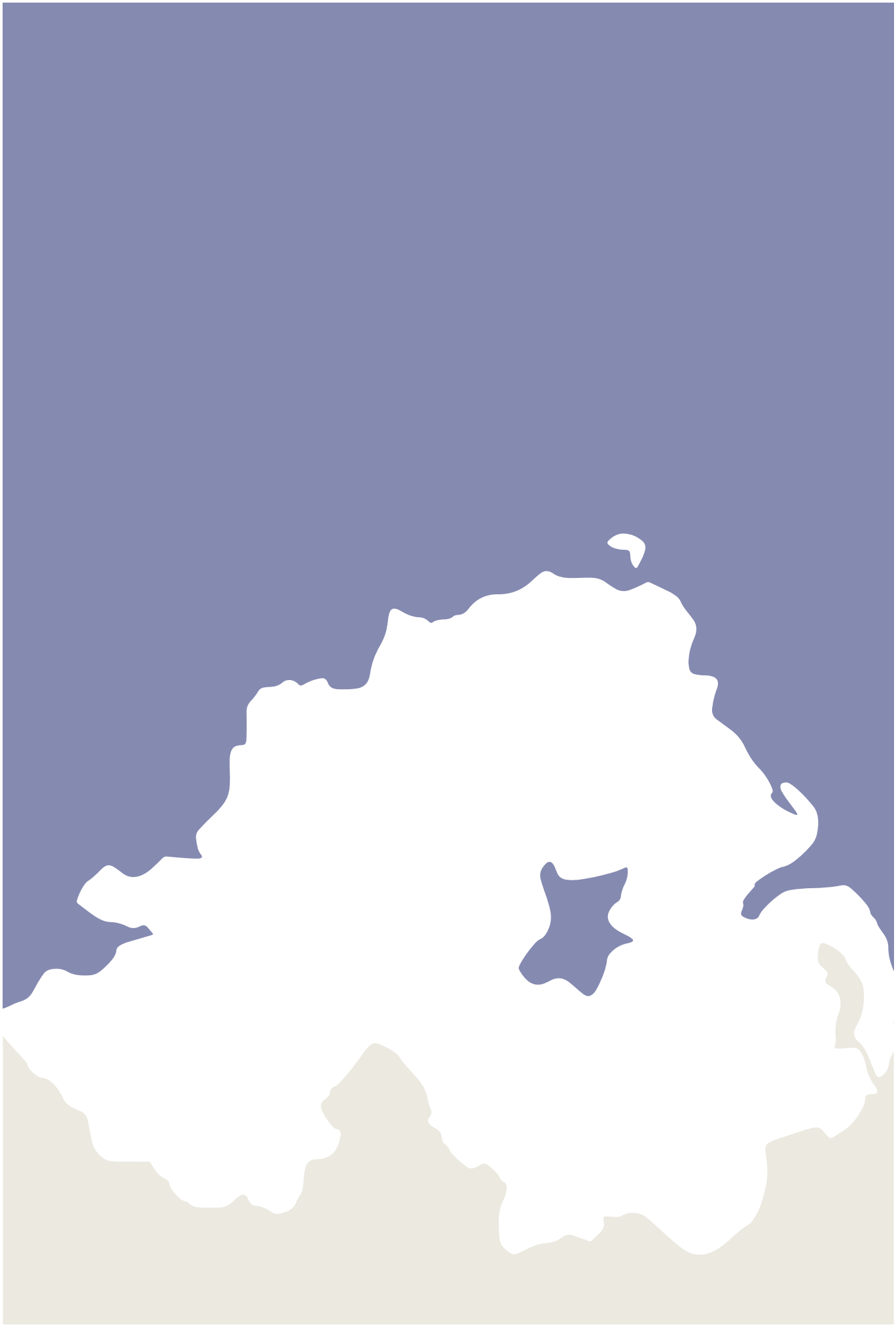
We recommend a number of measures to strengthen the patient voice:

- **more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;**
- **the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;**
- **the Patients and Client Council should have a revised constitution making it more independent;**
- **the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;**
- **one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).**

In implementing the above recommendations, the leaders of the Northern Ireland health and social care system should be clear in their ambition, which is in our view realistic, of making Northern Ireland a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time.

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

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

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

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

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

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

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

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

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

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

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

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

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

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

"I was not made aware of any clinical concerns or patient safety issues regarding urology services by the Chair of the Board, by the Chief Executive, Medical Directors or Operational Directors."

10:52

Just for the note of the Panel, if I could ask you to go back to your answer at WIT-100488, and this is paragraph 26 of your statement:

"We have issued urology concerns and issues brought to my and the Board's attention." You have summarised some of these. I don't want to take the sentence that you have stated at 50.1 out of context, but I want to tie up some of the issues around urology that were in fact brought to the Board and give you an opportunity to comment on whether you consider some of these to represent both clinical concerns and patient safety issues.

10:52

10:53

10:53

At paragraph 26.1, you've detailed in a tabular form some of the meetings where urology concerns were raised and I just want to go through a couple of these. The meeting at the Trust Board on 30th November 2017 and in the detail column you say:

"Waits on cancer pathways. Patients continue to be in excess of the 62 day pathway target associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper

10:53

and lower gastrointestinal specialties."

Then at that same meeting there is a mention just below that on the corporate dashboard, "cancer pathways, 62 days" and at the bottom of that table, it says, the last sentence: 10:54

"Again the majority of 62 day pathway breaches for the Trust continue to be within urology."

10:54

If we go over the page at the entry of the Trust Board meeting of 24th May 2018. Again in the detail column there is reference to the pathway again, this is seven months later, this meeting. And you say:

10:54

"Performance against the 62 day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. The less favourable performance is associated with the total volume of patients on these pathways which present increased demand on the 10:55 resources available, including red flag outpatient and diagnostic capacity. The two predominant breaching specialities in 2017 and 2018 were urology, sitting at 46%, and breast surgery sitting at 14% which was reflective of workforce pressures demonstrated 10:55 throughout 2017 and 2018."

The next entry in that column for this meeting on 24th May 2018 relates to outpatient assessments, and

this is your comment:

"Waits over 52 weeks for SHSCT specialities are reported across 13 specialties; breast family history, cardiology, diabetology. Endocrinology, ENT, gastroenterology, general surgery, neurology, orthogeriatrics, orthopaedics, rheumatology, thoracic medicine and urology, all of which have established capacity gaps or accrued backlogs." 10:55

Then in the meeting from 29th November of the Trust Board, again the 62 day waits, the majority of these were in urology. The Trust Board meeting on 24th January 2019, the in-patient day cases comment says this: 10:56

"In-patient day case waits over 52 week at the end of December has increased with 2662 people waiting across seven speciality areas: Breast surgery, ENT, general surgery, orthopaedics, pediatrics, pain management and urology." 10:56

And again below that at that meeting in January 2019 the 62 day pathway, the majority of breaches occurred are within urology. 10:57

Over the page, in May 2019, Trust Board meeting 23rd May - for the transcript we are now on page WIT-100491 - under elective care, it says:

"In-patient day case waits over 52 weeks largely continue to increase in line with regional trends. At the end of March 2019, 2700 people were waiting across nine speciality areas for over one year: breast surgery, cardiology, ENT, general surgery, gynaecology, orthopaedics, pediatrics, pain management and urology. Whilst the average waiting time is 37 weeks within the 95th percentile wait at 119 weeks pain management the longest routine wait remains within urology at 269 weeks." 10:57 10:58

At that same meeting on 23rd May 2019 the corporate dashboard indicated that the cancer pathway 62 day breach, the majority of breaches continued to be within urology. 10:58

That was also the case at the Trust Board meeting on 28th August 2019. The meeting on 3rd September 2020 - for the transcript this is WIT-100493 - there is a Performance Committee meeting and an update, a direct quote from that meeting has been given in your comment, section, and it says: 10:58

"Mrs. Magwood stated that the Trust has received a new investment for the seventh Urology Consultant. Recruitment is currently ongoing and it is anticipated that the seventh consultant will be in post in quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and 10:58

urgent cases with little anticipated impact on routine waits."

Then the Trust Board meeting on 22nd October 2020 says the following: 10:59

"In-patient day case waits and planned repeat treatments increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment. The Trust has received in year 10:59
investment of £200,000 for the urology seventh consultant. Recruitment is currently ongoing and it is anticipated that the seventh consultant will be in post in quarter 4. The additional capacity created by this post will be targeted to the red flags and urgent, with 10:59
little anticipated impact on routine waits."

That's information that came before the Board in relation to urology over that snapshot three year period. It's clear that waiting lists are getting 11:00
longer, the cancer performance objectives around the 62 day wait are being breached across the Board in some respects but specifically in urology. There is a mismatch with capacity and demand, there is staff shortages that are clear. Towards the end, the last 11:00
couple of examples that I read out, it seems to be the case that any attention being given to routine waits has all but been abandoned in favour of red flag and urgent, would that be a fair reflection on those

entries?

A. It would be, yeah. When we had an executive in place then there would have been waiting list initiative monies that would come and those would all be gear towards red flag cases, that would just enhance that too. 11:00

43 Q. Was there ever any curiosity expressed by the Board given that feedback, and urology does jump out - I know it jumps out at us for obvious reasons, but there does seem to be a bit of a theme - was there any questioning 11:01 of, for example, Mrs. Magwood around well what has been put in place about waiting lists, what measures are there at that time, because at this time you were looking just at numbers and breaches of targets effectively, that's what they represent; but do you 11:01 recall anything like that being discussed?

A. Up until the Performance Committee was established then I would have an exposure to the discussions around performance, the Performance Committee I don't attend. But I do recall conversations where we had looked at 11:01 the measures we were taking on recruitment to ensure that we had the staffing numbers in place and then whether or not we had the resources, the additional resources required then to deliver the services or additional clinics or operations in that regard. But 11:01 maybe if I could be so bold as to say that you have the Chair of the Performance Committee coming up in terms of the very specifics around, that might be helpful, but certainly where we are at as a Trust, the

And I think the reflections that I'm getting back from the people that are involved in that now, is that we certainly have a bit of refinement to do in terms of how we report data and use data, but I think we feel that we have a stronger grip on the organisation in terms of understanding how all of the information flows throughout the organisation and we make decisions and drive improvement based on patient safety and quality.

14:12

At the operational governance level then, as part of the reaction to what went on before and a realisation that the Acute Directorate was too big to function properly, when I became Chief Executive I split the Directorate into Directorate for Surgery and Cancer Services, and a Directorate for Medicine and Unscheduled Care. And, again, those two directorates in particular are more immature than the other directorates in the Trust because we've had to develop more staff to actually support some of the functioning in there to make sure that we capture, you know, patient safety and quality issues through the governance system as robustly as possible. Right.

14:12

14:13

14:13

So, what we have done is to try and support all of that, and this was introduced when I was Medical Director, have a weekly governance meeting. So it's a live governance feed, half eight to half nine every Thursday morning, when, under all of the headings that are to do with patient safety and quality, there's a

14:13

report done through to the Executive Directors in the Trust other than me. So it comes to the Director of Medicine, Nursing, Social Work, but not the Finance Director either, and all of that is run through and then that is escalated on a weekly basis to the Senior Leadership Team. We challenge the information that comes in there, and this is reported every week, and then pursue, you know, the agenda around improvement in relation to that. 14:14

We've now been doing that long enough I think that we have built up an awareness of some of the patterns. We've certainly driven improvement in some of the areas such as how we report out on incident reports. So Datix, for example, and the IR1 reporting system. We introduced additional software in May 2022 that has really bolstered that in terms of the usefulness of it. So I think that has given the Clinical and Social Care Governance teams, along with the operational teams, more information in terms of how we triangulate data. 14:14

So, for example, at the beginning when I went along in January 2019 to look for the supporting evidence around, you know, where is the heat in the system in relation to quality and safety incidents? It was really difficult to pick it up, because the information wasn't speaking to itself internally. We have improved on that quite a bit in that there's a number of feeds now that go into Datix, including the reporting through 14:15

Southern Health and Social Care Trust

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GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	9th September 2021		
Agenda item	Clinical and Social Care Governance Report		
Accountable Director	Dr Maria O'Kane		
Report Author	Name	Caroline Doyle	
	Contact details	Personal Information redacted by the USI	
This paper is presented for: **Information**			
Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care	
	☐	Supporting people to live long, healthy active lives	
	☐	Improving our services	
	☐	Making best use of our resources	
	☐	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.* *It details how it impacts on the people we serve.*

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

1. Detailed summary of paper contents:
The purpose of this paper to provide a report to Governance Committee (September 2021) on a number of Trust Clinical and Social Care Governance Indicators. This report provides information on Incident Reporting, SAIs, Catastrophic Incidents, Patient Safety and Quality Measures, Service User Feedback and Ombudsman cases.
2. Areas of improvement/achievement:
• 24 SAI Reports submitted this quarter • Number of Incidents relating to staff shortages caused by COVID-19 has reduced • Reduction in the number of reopened complaints
3. **Areas of concern/risk/challenge:**
• Number of Outstanding Incidents has increased • Number of SAI notifications submitted to HSCB has increased

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	This links to the risk of harm to the SHSCT population through inability to access safe, timely and appropriate care.
Board Assurance Framework	Yes
Equality and Human Rights	No

Southern Health and Social Care Trust

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Clinical and Social Care Governance Report September 2021



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

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Appendix 1.0 Healthcare Complaints Analysis Tool

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

1.0 Purpose of Report

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

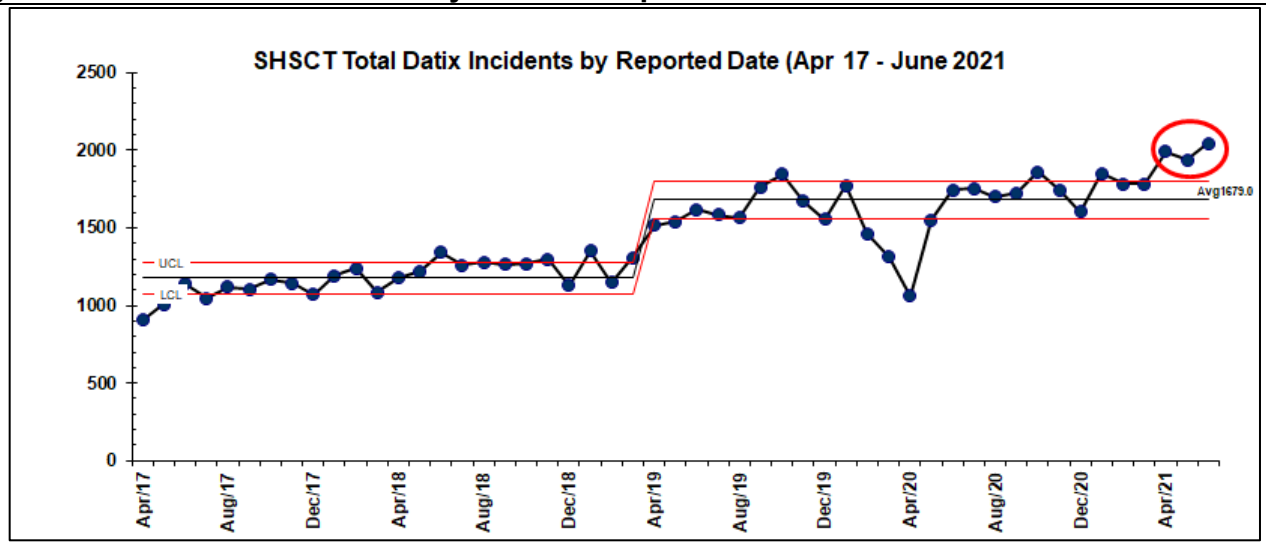
- **Incident monitoring to include Serious Adverse Incident and reporting timeframes**
- **Patient safety & quality measures**
- **Complaint monitoring**
- **Compliment monitoring**

The report analyses activity for the period **1st April – 30th June 2021 (Quarter 1),** with the exception of Patient Safety & Quality measures which are for the previous quarter **(January - March 2021, Quarter 4).** Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of future occurrence.

To set the wider context, this quarterly reporting period – **01/04/2021 to 30/06/2021 -** reports on Clinical and Social Care Governance indicators during the CoronaVirus pandemic period.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

2.0. Incident Reporting (via Datix)[1]

2.1 Total No. Incidents Logged via Datix	Fig 1.0 – Total SHSCT Incidents by Month 01 April 2017 – 30 June 2021.
Overall Trust Position In Q1 2021/22 - SHSCT directorates reported: ▪ 5971 IR1 incidents ▪ Forecast for the year based on this quarter 23,884 ▪ 2020/21 – **20,153 ↑4.9%** ▪ 2019/2020, **19,207** IR1 incidents **↑28%** ▪ 2018/2019, **15,043** IR1 incidents **↑14%** ▪ 2017/2018, **13,219** IR1 incidents This quarter has seen a significant rise in overall reported incidents in each month, demonstrated by special cause variation with 3 upper confidence level breaches.	

[1] Monthly incidents are now reported on the basis of the date on which the incident was reported via Datix and not the date that the incident occurred.

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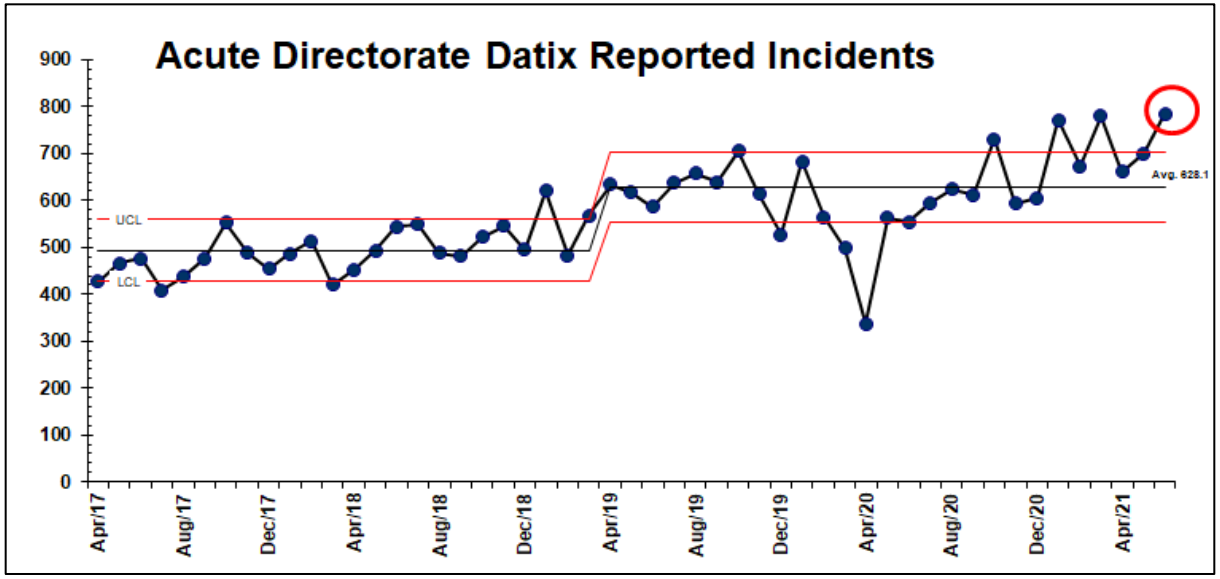
Fig 2.0 Operational Directorate Monthly Datix Incidents 01 April 2017 – 30th June 2021.

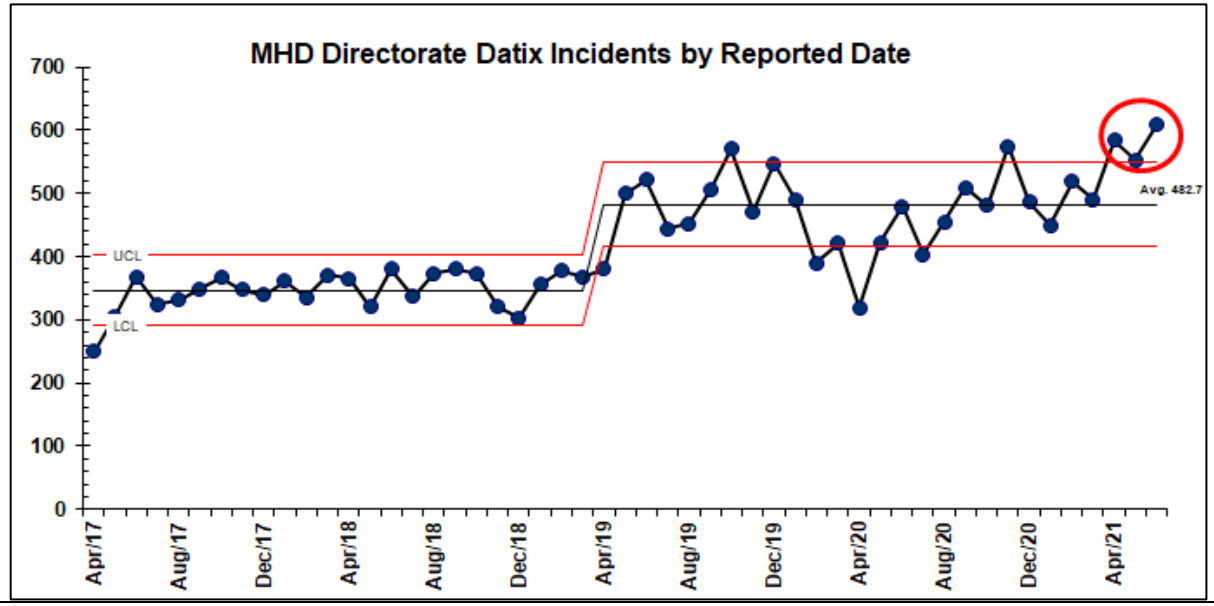
Directorate Position

In this quarter the Acute Directorate has seen a significant increase in incident reporting for the month of June, demonstrated by special cause variation with a single upper confidence interval breach. This follows 3 other significant breaches in the past year previously reported.

Since January 2021 the Acute Directorate identified an increase in reporting due to the COVID-19 pandemic. There has also been an increase of Violence and Aggression incidents (further broken down in the V&A section), with all incidents involving security being reported.

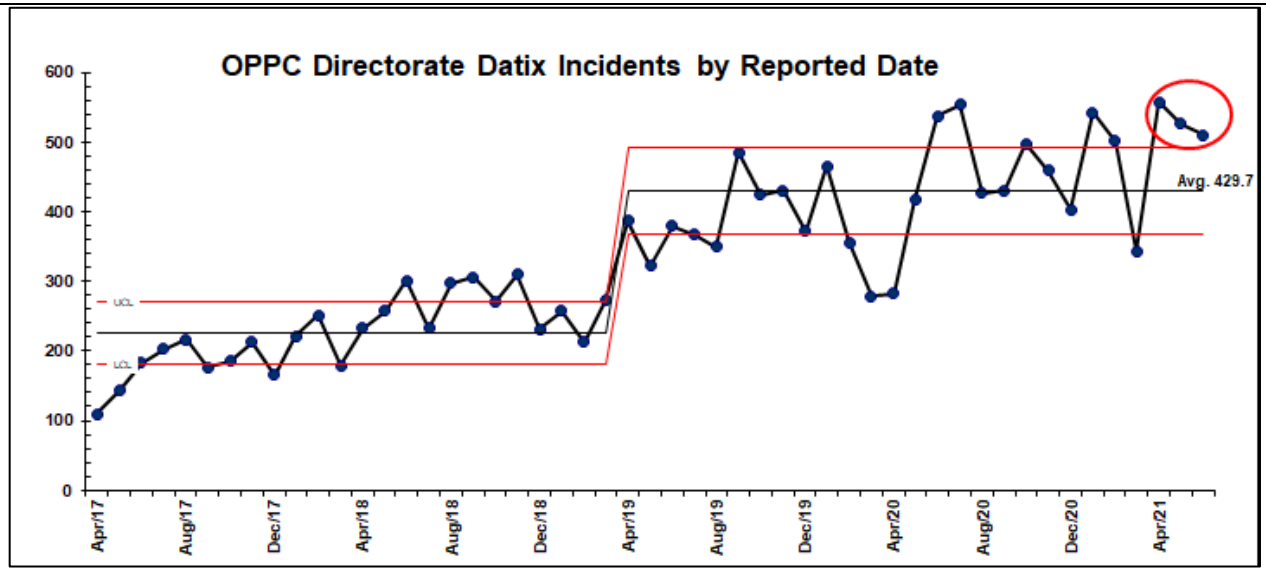
In this quarter the Mental Health Directorate (MHD) has seen a significant increase in incident reporting in all 3 months, demonstrated by special cause variation with 3 upper confidence breaches. This follows 1 other significant breach within the past year (previously reported).



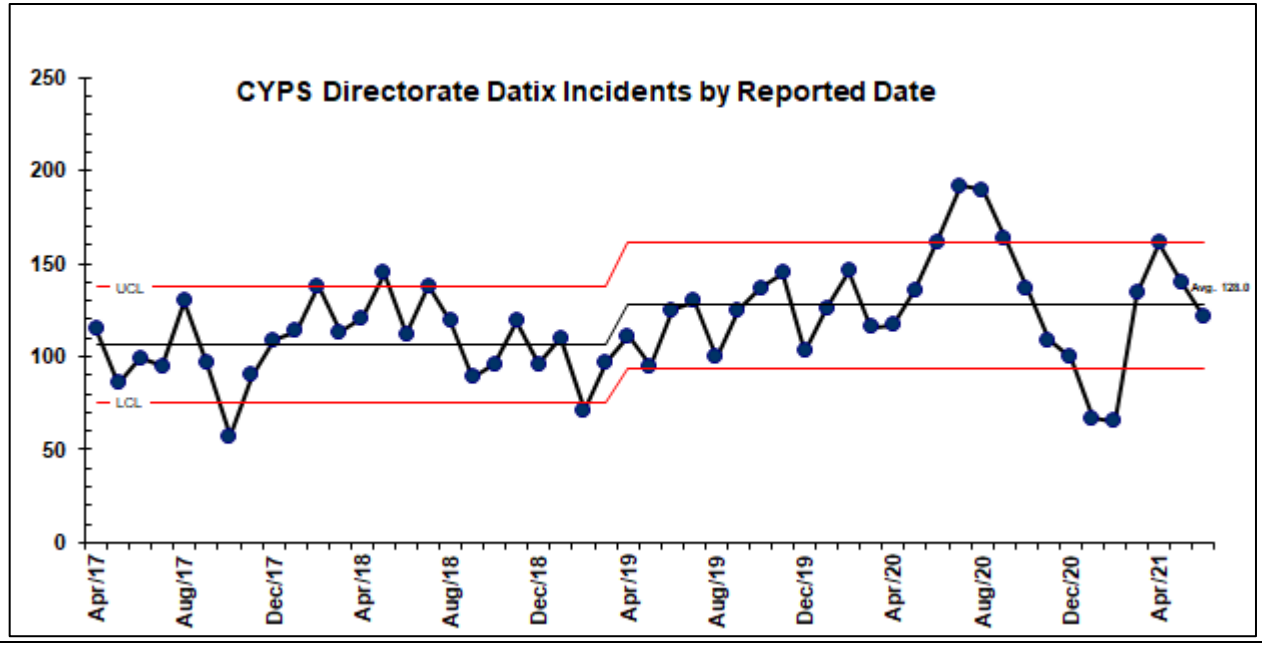


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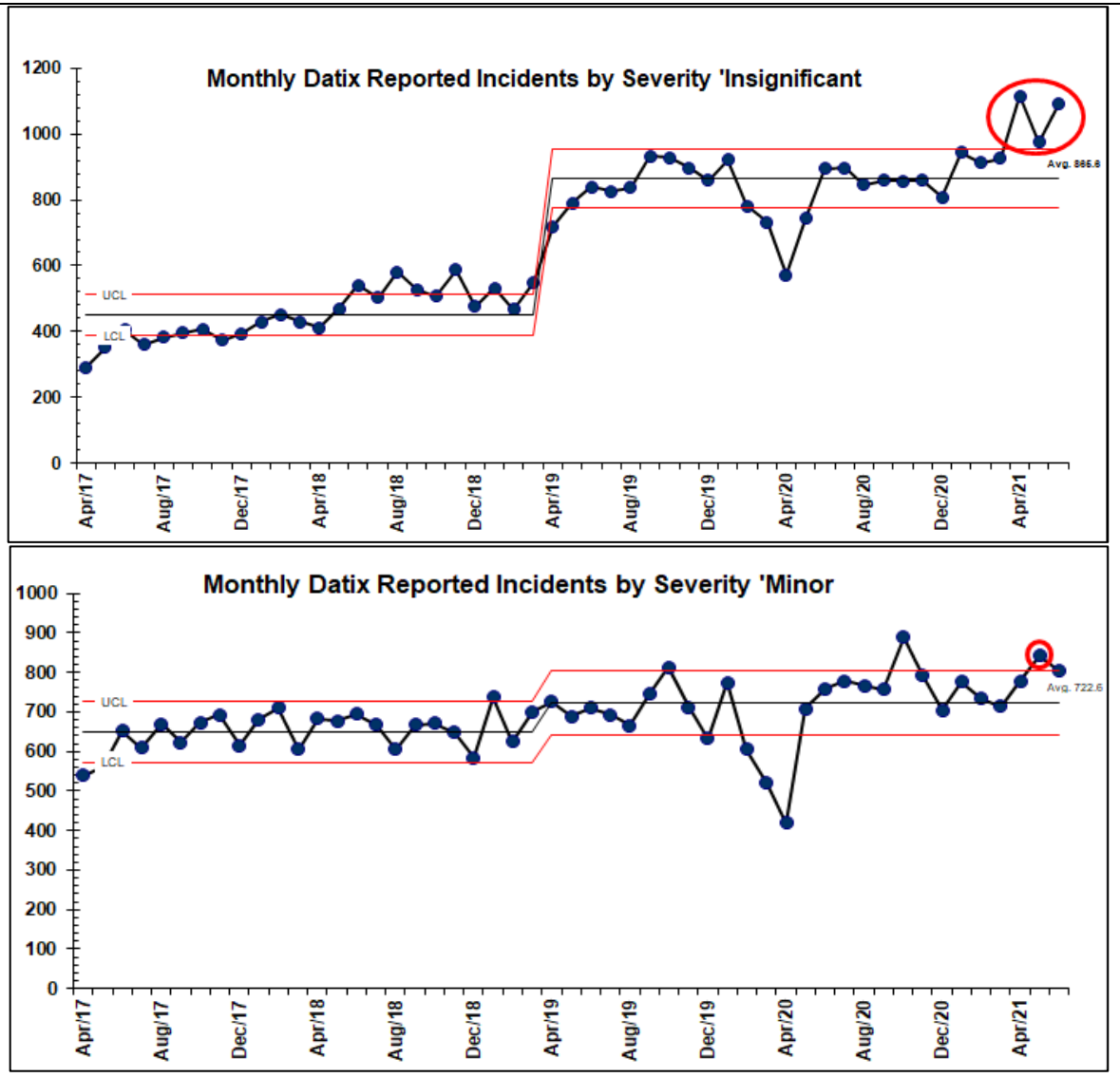
This quarter OPPC has seen a significant increase in incident reporting in all 3 months, demonstrated by special cause variation with 3 upper confidence breaches. This follows 4 other significant breach within the past year (previously reported).
This is thought to represent a healthy reporting culture which is now including the increased awareness of dysphagia type incidents reporting of which commenced in March 2021 across the Trust and Independent sectors.



In this quarter CYPS has seen no significant increase in reported incidents. The 3 other significant increases within the past year have been previously reported. The decrease in reporting this quarter is thought to be in relation to a more settled period within the residential units.



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2.2 Incident Severity[2]	Fig 3.0 - Total SHSCT Monthly Incidents by Severity 01 April 2017 – 30 June 2021
Q1 2021/2022 (Apr – June 2021) **53%** of SHSCT IR1 Incidents categorised as severity 'Insignificant' In 20/21 the reporting of insignificant incidents dropped to 49.93**%** of all incidents. In this quarter there has been a significant increase in the reporting of incidents categorized as insignificant in each month. This is demonstrated by special cause variation with 3 upper confidence limit breaches, which reflects a positive culture of reporting. Such a culture contributes to learning, helps to prevent re-occurrence, reducing avoidable harm and increasing safety and quality. 26.2% of these incidents have not been categorised. 36% are Behaviour related incidents and 17% are in relation to Falls. **40%** of SHSCT IR1 Incidents categorised as severity 'Minor' In this quarter there was 1 month where there was a significant increase in incidents categorized as Minor. This is demonstrated by special cause variation with a single upper confidence limit breach. 16% of these incidents have not been categorised. 20% are in relation to	

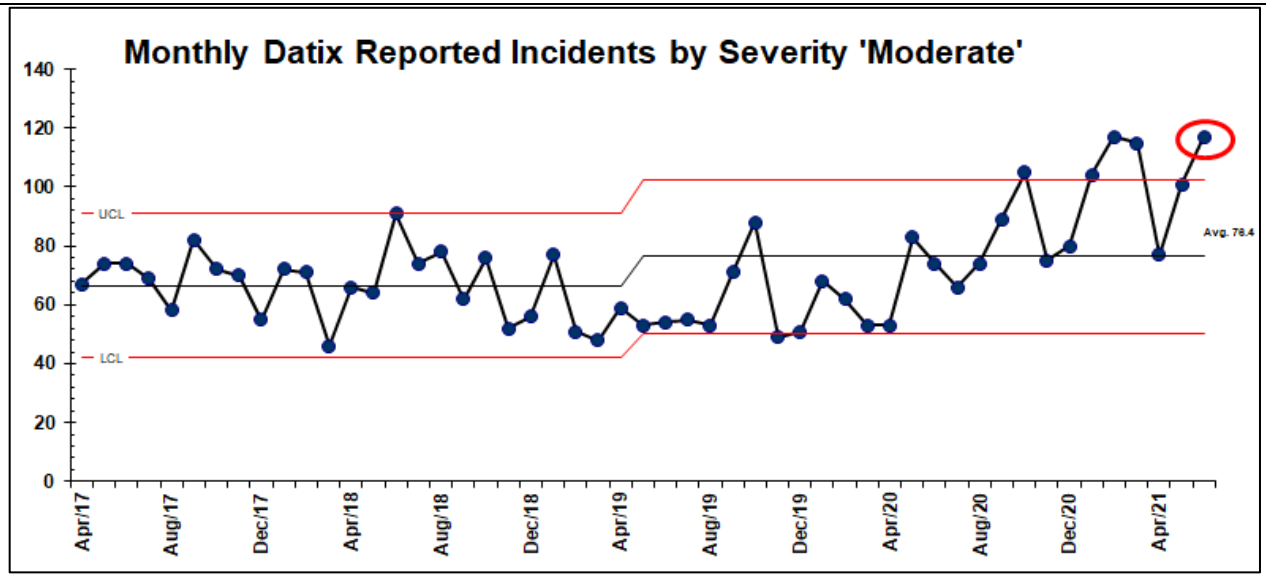
[2] Includes incident Severity for 'unapproved incidents' (2021) which could be subject to change on final approval of the incident

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Behaviour related incidents and 17% are in relation to Falls.

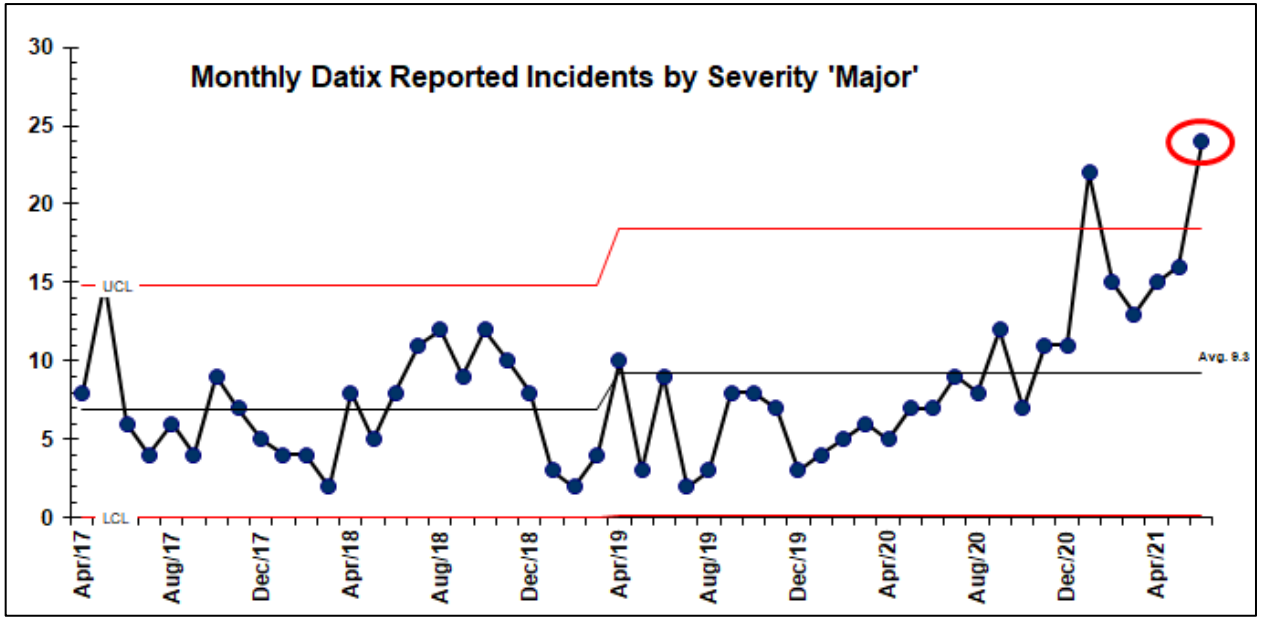
4.95% of SHSCT IR1 Incidents categorised as severity 'Moderate'

Over the last 3 months the incidents sit above the mean with a single upper confidence limit breach in June 2021. 36% of these incidents have not been coded. 13% are related to Medication and 9% are Behaviour related incidents.



0.92% of SHSCT IR1 Incidents categorised as severity 'Major'

This quarter the number of Major report incidents has increased. 36% of these incidents remain uncoded and 23% relate to Covid-19. There was an upper confidence limit breach in June and there has been 8 consecutive data points above the mean.
36% incidents remain uncategorised and 23% in relation to Infection Prevention Control.



Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

0.18% of SHSCT IR1 Incidents categorised as severity 'catastrophic'

Numbers of catastrophic incidents remain low. In this quarter there has been no significant change in incidents reported as Catastrophic. The previous single upper limit breach was reported in the last quarter.
27% of these incidents remain uncategorised the categorised incidents include incidents involving suicides and HCAI Deaths.

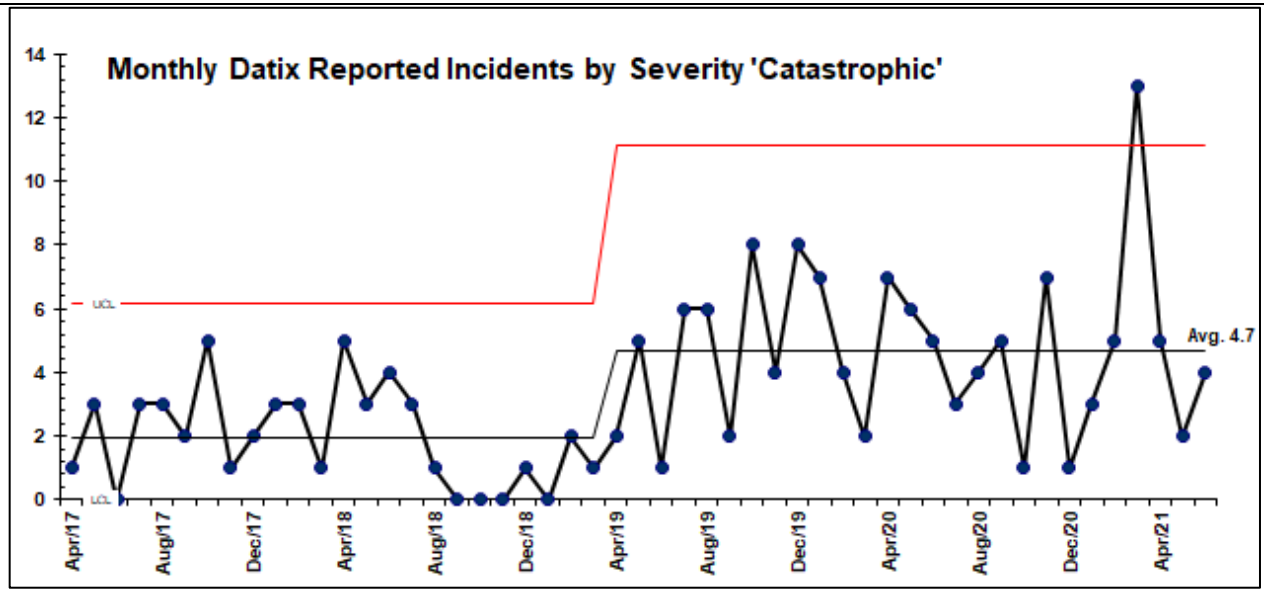


Table 1.0 provides the breakdown of all SHSCT catastrophic incidents by Directorate since January 2020.

Directorate/Catastrophic Incidents	Jan - Mar 20	Apr - Jun 20	July - Sept 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21
Acute Services	3	4	3	3	9	6
CYPS	2	0	1	0	2	0
MHD	5	11	8	6	6	4
OPPC	0	2	1	0	4	1
Grand Total	10	17	13	9	21	11

Table 1.1 details overall proportion of incidents in each severity category year on year.

Year % Severity	Insignificant	Minor	Moderate	Major	Catastrophic
% 2017/18	35.34%	57.75%	6.13%	0.57%	0.20%
% 2018/19	40.85%	52.96%	5.32%	0.61%	0.13%
% 2019/20	52.48%	42.93%	3.87%	0.35%	0.30%
% 2020/21	49.93%	43.31%	5.69%	0.74%	0.30%
% 2021/22	53.34%	40.61%	4.94%	0.92%	0.18%

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Table 1.2 Details Total Trust Incidents by year, by severity. 2021/22 forecasted for the full year.

FY	Insignificant	Minor	Moderate	Major	Catastrophic	Unallocated	Grand Total
2017/18	4671	7634	810	75	27	2	13219
2018/19	6145	7967	801	92	20	18	15043
2019/20	10080	8245	743	68	58	13	19207
2020/21	10063	8728	1146	149	60	7	20153
2021/22	12740	9700	1180	220	44	0	23884

2.2 Incident Severity Cont'd - Catastrophic Incidents and SAI Notifications

Between 1st April to 30th June 2021 – 11 catastrophic incidents (0.18%) were recorded. 8 of these incidents have also been notified to the HSCB as SAI's. In addition a further 19 SAI's were also reported to the HSCB and are set out in Table 4.0 below.

Summary: Total Number 32
Catastrophic Incident reported during period, not SAI – 5
Catastrophic Incident reported during period and reported as an SAI between 01/04/2021 – 30/06/2021 – 6
Catastrophic Incident reported before 01/04/2021 reported as an SAI between 01/04/2021 – 30/06/2021 - 2
Other Incidents reported as SAI's – 19 (1 insignificant, 2 minor, 10 moderate and 6 major – 2 of the moderate incidents was also a Never Event).

Table 2.0 – Catastrophic Incidents and / or SAI's notified to the HSCB by Directorate

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Personal Information	Personal Information redacted by the USI	n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Personal Information	Personal Information redacted by the USI	n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								outcome from M&M/SJR.
Personal Information	[redacted]	n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Personal Information	[redacted]	n/a	n/a	Child died in ED following injuries sustained in a road accident.	Acute	Catastrophic	No	No immediate learning.
Personal Information	[redacted]	n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Personal Information	[redacted]	15/06/2021	Screening processes	Patient physically attacked two members of nursing staff with a knife.	Acute	Minor	Yes	Debrief with staff. Detox policy was not initiated.
Personal Information	Personal Information redacted by the USI	04/06/2021	Screening processes	Baby transferred to SCBU following low APGAR scores. Subsequently transferred to RVH for management.	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	04/06/2021	Screening processes	Following an emergency caesarean section patient experience 6500ml blood loss and required	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
				hysterectomy. Ventilated and transferred to ICU.				report recommendations. Maternity asked to comment
Personal Information	Personal Information redacted by the USI	03/06/2021	Screening processes	Patient attended for planned removal of ureteric stent. Pre-op bloods were not consulted prior to procedure which indicated there was new renal impairment. Patient readmitted with renal failure and sepsis. Subsequently transferred to RVH for bilateral nephrostomies.	Acute	Major	Yes	Available imaging and blood results at the time of planned procedure on Personal Information redacted by the USI suggested that the clinical situation had changed, this did result in a change of plan. However this change in plan was not communicated with the RVH.
Personal Information	Personal Information redacted by the USI	12/04/2021	Screening processes	Retained swab post caesarean section.	Acute	Moderate	Yes	All swabs must be counted thoroughly and swab counts done according to protocol. This must also be documented in the hand held notes. Patient must be kept informed about this.

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Personal Information	[redacted]	25/06/2021	Screening processes	Retained swab post caesarean section.	Acute	Moderate	Yes	All swabs must be counted thoroughly and swab counts done according to protocol. This must also be documented in the hand held notes. Patient must be kept informed about this.
Personal Information	Personal Information redacted by the USI	24/05/2021	Screening processes	Delay with RVH accepting this patient, who had an unstable spine fracture, for management.	Acute	Moderate	Yes	The RVH was contacted by the SHSCT for transfer as per unstable spinal protocol. The RVH should have accepted patient as per protocol.
Personal Information	Personal Information redacted by the USI	07/06/2021	Screening processes	Personal Information redacted by the USI	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	24/05/2021	Complaints process first.	Patient experience reduced vision in both eyes two days following total hip replacement.	Acute	Major	Yes	Patient referred to Belfast Trust for management. Ischemic optic neuropathy

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								secondary to hypotension. Patient was on medication for hypertension, Consideration for review of hypertension medication.
Personal Information	[redacted]	04/06/2021	Screening processes	Following a planned caesarean section patient experience 5000ml blood loss.	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations. Maternity asked to comment
Personal Information	[redacted]	08/04/2021	Internal SEA and then escalated to a Level 1.	FAST positive patient. Delays in getting patient to hospital. On arrival difficulty in establishing contact with on-call radiologist. After RVH accepted patient for management further delays experienced in obtaining ambulance transport.	Acute	Major	Yes	CT brain should be completed within 45 minutes of admission.
Personal Information	Personal Information redacted by the USI	29/04/2021	Screening processes	Patient underwent recon nailing of his right femur and was discharged home. At review clinic 8 weeks later it was noted that the patient's	Acute	Major	Yes	True lateral x-ray should be undertaken in theatre for all

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
				right leg was 2cm shorter than the left with some external rotation of the right foot.				patients who are undergoing recon nailing of the femur. Patient referred to Belfast Trust for management.
Personal Information	Personal Information redacted by the USI	29/04/2021	Screening processes	Delay in review due to Covid-19. Patient diagnosed with advance uterine sarcoma.	Acute	Major	Yes	Patient referred to Cancer MDM.
Personal Information	Personal Information redacted by the USI	15/04/2021	Screening processes	Patient experienced ruptured aortic dissection out of hospital. Had been in ED 3 days previously and treated for an upper respiratory tract infection.	Acute	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	07/06/2021	Early Alert notified on Personal Information redacted by the USI On 10/05/2021 Early Alert was discussed at the HSCB Incident Review Meeting and the Group confirmed that NO SAI is to be submitted. On 28/05/2021 the HSB advised that the Early Alert record had been reopened and requested that an SAI notification be made in respect of this incident given the potential risk posed by	On Personal Information redacted by the USI a Personal Information old female, subject to an Interim Care Order and residing in foster care since Personal Information, left her foster home and was reported as a missing person to the PSNI. It transpired that the young person was abducted by her father and taken to Personal Information.	CYPS	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
			father to daughter.					
Personal Information	Personal Information redacted by the USI	01/04/2021	Delay in receipt of SD1 / Information gathering	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	01/04/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	30/06/2021	n/a	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	26/04/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	Personal Information redacted by the USI	08/04/2021	Delay in receipt of SD1 from PSNI	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								recommendations.
Personal Information	[redacted]	10/06/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Personal Information	[redacted]	01/06/2021	Adult Safeguarding and Public Prosecution Service processes. Competing resourcing priorities associated with the pandemic, restarting of services and the completion of Deprivation of Liberty applications as part of the Mental Capacity Act.	Allegation of physical abuse of service user by one care assistant against another.	OPPC	Insignificant	Yes	Staff member suspended from all duties by the Home Management with immediate effect
Personal Information	Personal Information redacted by the USI	17/05/2021	Delay in Acute notifying NAH of the death and therefore delay in the notification.	Choking incident while hospital inpatient. CPR commenced. Client subsequently died.	OPPC	Major	Yes	All wards and departments advised and instructed to review their defibrillation machine

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								pad stock and remove any incorrect stock and replace immediately with the correct pad stock. Ward Sisters instructed to check medical devices for correct compatible products. Resuscitation trolley checklist updated to include a prompt for staff to check the compatibility of the defibrillator pads as well as a picture of the correct pads to be completed on the regular weekly crash trolley and daily defibrillator checks. The Cardiac arrest protocol was reissued to all staff and the staff asked to sign and

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								date they have read same. Protocol discussed at daily handovers safety brief. Ward Sisters to monitor compliance with reading of protocol and Nurse Manager will monitor compliance at Ward Sister 1 to 1. A review of the nursing staff Immediate Life Support (ILS) training was conducted by the Nurse
Personal Information	Personal Information redacted by the USI	01/06/2021	Delay in Keyworker being notified by Home.	Resident was observed with the call bell lead wrapped loosely around his neck.	OPPC	Moderate	Yes	Call bell changed to one with no lead. Client observed closely overnight. GP, relevant services and Next of Kin notified the next morning.
Personal Information	Personal Information redacted by the USI	01/06/2021	A joint protocol Police Service for Northern Ireland (PSNI) / Southern Health and Social care Trust (SHSCT) Adult Safeguarding Investigation. PSNI advised strong case to	Allegation of monies missing from Service User's bank account.	OPPC	Moderate	Yes	Referral was made to Safeguarding and the PSNI. Care staff ceased from carrying out shopping for resident. Resident's

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
			secure a prosecution in relation to this incident and that the PSNI are forwarding a report to the Public Prosecution Service (PPS).					family informed.
Personal Information	Personal Information redacted by the USI	06/05/2021	Care Home did not follow process for reporting incident to Trust. Trust advised of incident by family.	Residents family were contacted in error and informed their mother was passing away and that they needed to attend the home. Incorrect family notified.	OPPC	Minor	Yes	Staff member who contacted wrong family has reflected on incident. All other staff advised of the incident in order to raise awareness and try and reduce the likelihood of a similar incident occurring in the future. Electronic recording system assessed to determine if any adjustments could be made to try and reduce the likelihood of a similar incident occurring in the future. Care Home Management provided an apology to each family.

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ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Personal Information	Personal Information	14/06/2021	Took time to ascertain the detail across the independent sector provider, and Trust services	Death of Service User following choking incident.	OPPC	Catastrophic	Yes	Emergency resuscitation commenced. Ambulance requested.

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director and Clinical Lead along with the Governance Coordinator. This process identifies any areas of immediate learning resulting from incidents to ensure they are acted upon

[3] This incident has been since upgraded to Catastrophic.

[3] Screening process as at Jan 2020.

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2.3 Incidents Classification[4]

Datix reporting introduced a new classification system which was adopted regionally by all HSCTs on 15/04/2019. This has introduced changes to categorisation and also requires an allocation of 'who' the incident involved.

Tables 3.0 and 4.0 below summarise:

- Total incidents (across all directorates) for the period April – June 2021, by who was involved.
- Trust Top 10 categories
- **24.7 (up from 20.9% last quarter) % incidents – uncategorised at the time of reporting**.

Table 3.0 below provides a breakdown of Incidents broken down by 'Who was involved'

Incident Involved	Q1 21/22 No. of Incidents	% Total	Q4 20/21 No. of Incidents	% Total	Q3 20/21 No. of Incidents	% Total	Q2 20/21	% Total	Q1 20/21	% Total
Patient & Service User	3545	59.37029	3178	58.69966753	2855	55	3116	60	2699	62
Staff	711	11.90755	891	16.45733284	936	18	723	14	754	17
Public / Visitors	52	0.870876	30	0.554118951	26	0	25	0	23	1
Organisational	183	3.064813	181	3.343184337	182	3	143	3	142	3
Uncategorised	1480	24.78647	1134	20.94569634	1208	23	1172	23	737	17
Total	5971		**5414**		5207		**5179**		**4355**	

Table 4.0 below provides a breakdown of the Top 10 Incidents by Category.

Categorised incidents cover 36% of the 5971 incidents, excluding 'uncategorised' and 'other'.

Qu 1 SHSCT 'Top 10' By Incident Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Uncategorised at time of Reporting	835	516	108	20	3	1482
Behaviour (Including Violence and Aggression)	1149	613	27	4	3	1796
Accidents/Falls	551	362	26	6	1	946
Medication/Biologics/Fluids	269	209	41	1	0	520
Pressure Ulcers	38	183	10	0	0	231
Other	92	65	11	1	1	170
Diagnostic Processes/Procedures	32	76	10	3	0	121
Communication	40	55	9	0	0	104
Maternity Care	5	68	14	2	0	89
Service Disruptions (environment, infrastructure, human resources)	29	41	9	0	0	79
Other Categories outside Top 10	145	237	30	18	3	433
Grand Total	3185	2425	295	55	11	5971

In this quarter the categories remains consistent to previous quarters pre the Covid-19 pandemic, this quarter there were no Infection Control Incidents in the Top 10, other than incidents in relation to the vaccine. Maternity Care and Service Disruptions appeared in the Top 10 this quarter.

Tables 5.0 – 8.0 provide a further drill down listing the top 10, by involvement, category and severity[5].

Table 5.0. Incidents involving Service Users - 59%. Falls and pressure ulcers are key patient safety areas further reported in section 3.0. Whilst table 5.0 provides details on all pressure ulcer and patient falls, section 3.0 reports on hospital acquired pressure ulcers and injurious fall sub-categories.

[4] Incident classification is now reported at the aggregated category level, accumulating all relevant smaller sub-categories. This themes incident classification at the highest level with further sub-category drill down available.

[5] Datix data quality impacts the categorisation, e.g. if IR1 incorrectly associates the incident to a staff member when a patient is the 'involved' person. Datix training investment is required for improvement alongside data quality processes.

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Q1 Apr - June 2021 Patient/Service User Incidents by Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Behaviour	814	406	19	3	3	1245
Patient Accidents/Falls	504	300	20	5	1	830
Medication/Biologics/Fluids	256	191	29	1		477
Pressure Ulcers	38	183	10			231
Other	92	65	11	1	1	170
Diagnostic Processes/Procedures	32	76	10	3		121
Communication	40	55	9			104
Maternity Care	5	68	14	2		89
Documentation	18	33	3	1		55
Infection Control Incident (Healthcare Associated Infection)	9	16	2	13	1	41
Other Categories outside Top 10	45	112	19	4	2	182
Grand Total	1853	1505	146	33	8	3545

Table 6.0. Incidents involving Staff – 11%

Q1 April - June 2021 Staff Incidents by Category	Insignificant	Minor	Moderate	Major	Grand Total
Behaviour (Including Violence and Aggression)	327	203	4	1	535
Accidents/Falls	39	51	5	1	96
Exposure to Environmental Hazards	14	28	0	0	42
Property	14	21	3	0	38
Grand Total	394	303	12	2	711

Table 7.0. Incidents at an Organisational Level – 3.06%.

Q1 Apr - Jun 2021 Organisational Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Service Disruptions (environment, infrastructure, human resources)	29	41	9	79
Medication/Biologics/Fluids	13	18	12	43
Fires, Fire Alarms and Fire Procedures	22	5	1	28
Security of Organisation's Property, Data and Buildings	10	6	1	17
IT Systems	0	11	1	12
Public Order/Crowd Control	2	2	0	4
Grand Total	76	83	24	183

Table 8.0. Incidents involving the public – 0.87%

Q1 Apr - June 2021 Organisational Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Accidents/Falls	8	11	1	20
Behaviour	8	4	4	16
Property	10	3	0	13
Exposure to Environmental Hazards	2	1	0	3
Grand Total	28	19	5	52

2.4 Incidents of Behaviour / Abuse including Self Harm

The following three tables (**Tables 9.0 – 11.0**) provide a further breakdown, by the person affected groups of the 1796 recorded incidents of Behaviour / Abuse by Severity.

Table 9.0

Of the 23 incidents recorded as Inappropriate/Aggressive Behaviour towards a Patient by Staff

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have all been reviewed, 11 of these have been incorrectly coded and the 12 remaining have been referred to Safeguarding and PSNI (where appropriate).

Person Affected - Patient/Service User	Severity					
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Missing Patient (absconded/abducted patient)	162	124	7	1	0	294
Self-harming Behaviour	153	122	4	0	3	282
Patient Behaviour that challenges	211	58	3	0	0	272
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	135	32	2	0	0	169
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	111	40	1	1	0	153
Inappropriate/Aggressive Behaviour towards a Patient by Staff	10	11	2	0	0	23
Use/Possession of Prohibited/Stolen Goods	18	4	0	0	0	22
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	0	12	0	1	0	13
Patient Restraint Processes	9	1	0	0	0	10
Patient refusal of diagnostic/therapeutic recommendations/interventions	5	2	0	0	0	7
Grand Total	814	406	19	3	3	1245

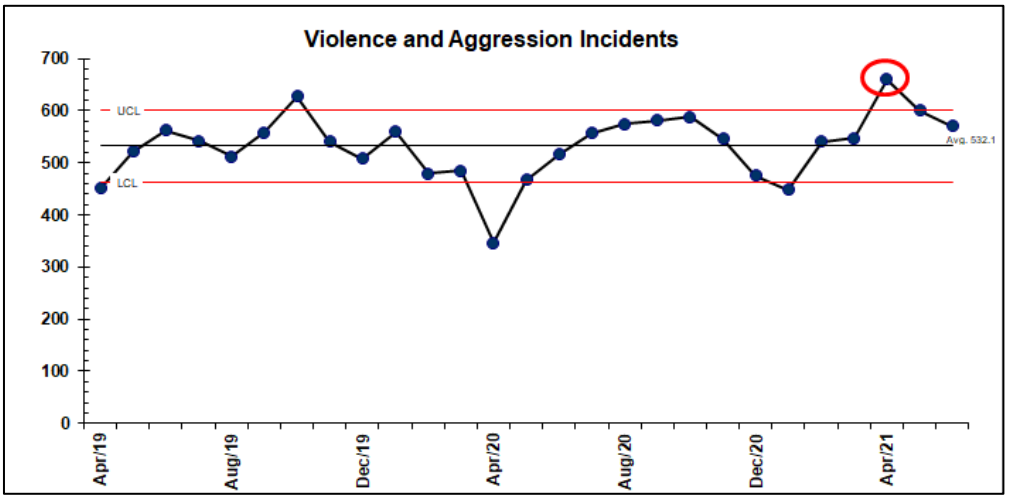
Table 10.0

Person Affected - Staff Member	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Grand Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	311	193	3	1	508
Other	10	6	1	0	17
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	1	4	0	0	5
Inappropriate/Aggressive Behaviour towards Staff by Staff	4	0	0	0	4
Persons Performing Unauthorised Acts	1	0	0	0	1
Grand Total	327	203	4	1	535

Table 11.0

Person Affected - Visitor	Severity			
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Grand Total
Other	4	3	4	11
Inappropriate/Aggressive Behaviour towards a Visitor by a Visitor	2			2
Persons Performing Unauthorised Acts		1		1
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	1			1
Inappropriate/Aggressive Behaviour towards Visitor by Staff	1			1

Figure 4 below shows the number of Violence and Aggression incidents reported since April 2019. This is not broken down by Person Affected. These incidents will include V&A against staff and Self Harming behaviour. As mentioned in previous sections there has been an increase in V&A incidents being reported within the Trust, one of the reasons is all incidents involving security staff are now being reported via Datix.



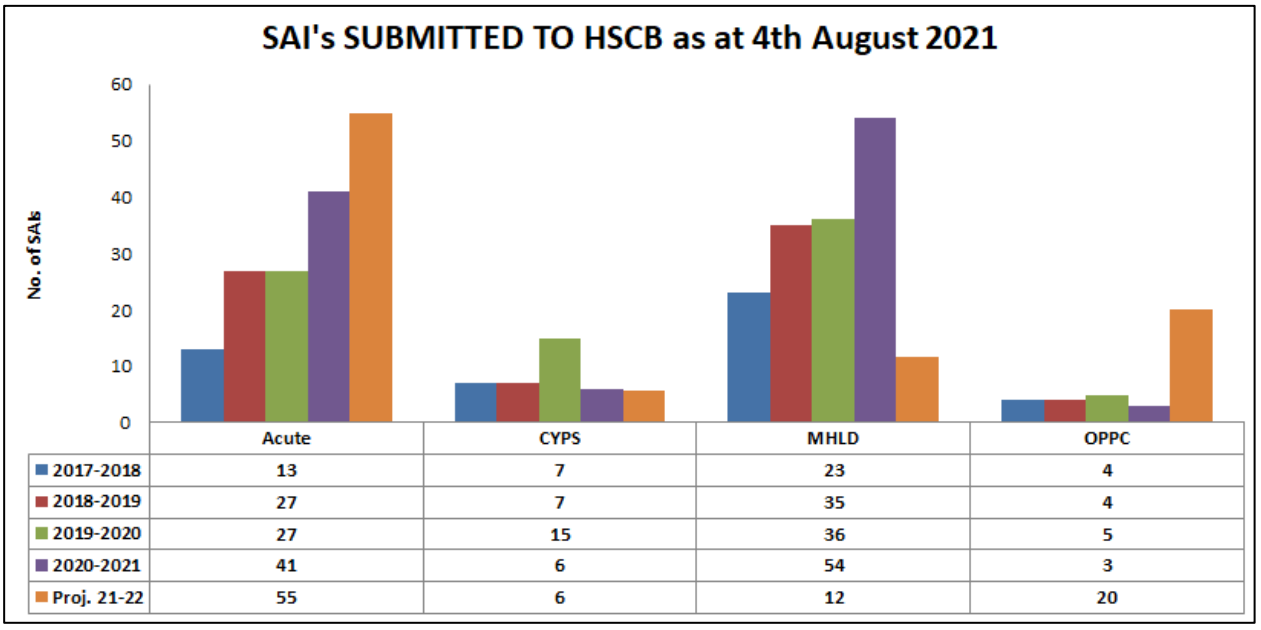
2.5 Incidents of / or attempted absconding and Absent Without Leave (AWOL)

Table 12.0 below provides a further breakdown, by category, directorate and severity of the 294 recorded incidents of missing or absconded or AWOL patients or service users.

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Person Affected - Patient	Severity				
Type of Missing Patient	Insignificant	Minor	Moderate	Major	Grand Total
Absconded/left without informing staff	108	108	6	1	223
Attempted to abscond/leave without informing staff	29	12	0	0	41
Failed to return from authorized leave	10	1	0	0	11
Left with notice contrary to advice	8	2	0	0	10
AWOL / Absconded (detained patients only)	7	1	0	0	8
Abduction	0	0	1	0	1
Grand Total	162	124	7	1	294

2.6 Serious Adverse Incident Investigations submitted to HSCB as at 04th August 2021



	Acute	CYPS	MHLD	OPPC
2017-2018	13	7	23	4
2018-2019	27	7	35	4
2019-2020	27	15	36	5
2020-2021	41	6	54	3
Proj. 21-22	55	6	12	20

2.7 Trust Performance against Regionally Agreed Timescales

Timescales for the completion of Serious Adverse Incidents are set out by HSCB:

- Level 1 - 8 weeks
- Level 2 - 12 weeks
- Level 3– timescales are agreed between the reporting organisation and the HSCB/PHA DRO

	In Timesc	Outside Tir	Total
Acute	14	20	34
CYP	1	3	4
MHD	16	21	37
OPPC	2	9	11
On Hold	n/a	n/a	2
Total	33	53	88
%	39	62	

Table 14.0

SHSCT currently have:

88 SAI investigations in progress[6]. 2 of which have been paused due to ongoing investigations by external bodies such as Safeguarding Board Northern Ireland.

33 SAI investigations (37.5%)[7] remain within the HSCB timescales for submission. 53 are outside of timescales and this is broken down by Directorate in table 15 below.

There are a number of contributory factors which influence the compliance of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

[6] SAIs notified in a period will vary from the number actively in progress or paused at any particular point in time.
[7] Compared with 21% in the previous quarter.

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- Appropriate team configuration to ensure appropriate level of clinical independence and expertise.
- Difficulties in obtaining external chairs / review team members.
- The prioritisation of SAI investigations within existing workloads.
- Necessary engagement with service users and their families, particularly where a death has occurred.
- Where the SAI investigation spans across 2 or more Trusts
- Capacity constraints on Clinical and Social Care Governance Teams, compared with current demand and complexity

As above there are 88 open SAI's as at 4th August 2021, this is compared to 83 in the previous quarter. A breakdown of the SAI activity has been provided below.

Ongoing SAIs last quarter		83
Add New SAI notifications:	Acute – 19, CYPS – 2, MHD – 4 and OPPC - 7	32
Less SAI reports submitted:	Acute – 11, CYPS – 4, MHD - 9	-24
Less De escalation of SAIs:	MHD	-3
Ongoing SAIs as at 04/08/2021		88

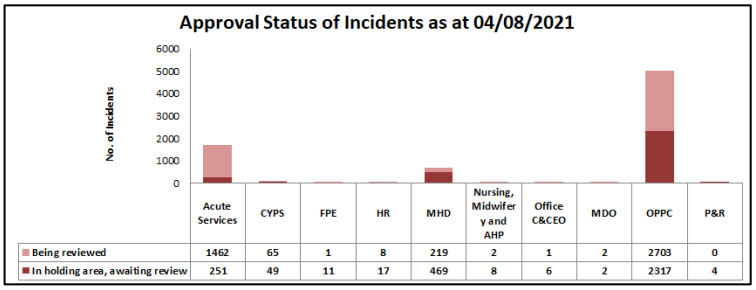
Table 15.0 sets out the detailed position on the progress of the 88 SAI investigations currently on-going as at 04/08/2021 (2 SAI investigation currently paused).

SAI Level	ACUTE			CYPS			MHD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales week 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB < Timescales weeks 26<	Within HSCB Timescales	Outside HSCB > Timescales weeks 26>	Outside HSCB < Timescales weeks 26<
Level 1	7	0	12	1	0	2	0	4	4	2	3	5
Level 2	5	4	2	0	1	0	14	9	3	0	1	0
Level 3	2	0	2	0	0	0	2	0	1	0	0	0
Totals	Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales	
	14	4	16	1	1	2	16	13	8	2	4	5

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2.8 Approval Status of Incidents[8]

Figs 5.0 & 6.0 highlights the number of incidents in each Directorate 'awaiting review' or 'being reviewed'. Incidents in the review process are not categorised by subject and the final severity rating has not been approved**.** In this quarter the number of unapproved incidents has increased within Acute and OPPC. MHD and CYPS numbers remain similar as last quarter.



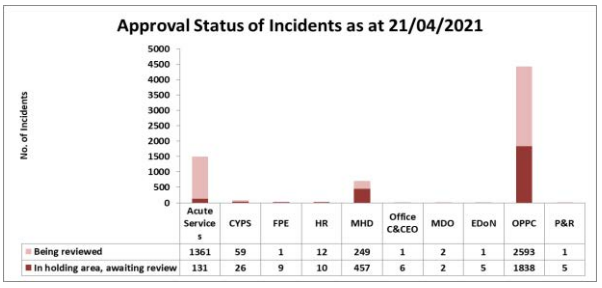


Fig. 7.0 Details the retrospective time frame for unapproved incidents.

Since the last quarter, there has been an 18% decrease in the number of 2020 incidents, 20% decrease in the number of 2019 incidents and 18% in 2018. There are 71 incidents from before December 2017 which remain unapproved. Directorates have been asked by the Medical Director for action plans to address the number of unapproved incidents.

	2010	2011	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Acute Services	1	1	0	0	1	3	5	10	86	314	1401	1822
Children and Young Peoples Services	0	0	0	0	0	0	0	0	0	4	127	131
Finance Procurement & Estates	0	0	0	0	0	0	0	0	0	1	11	12
Human Resources and Organisational Development	0	0	0	0	0	0	0	0	0	1	26	27
Mental Health and Disability	0	0	0	0	0	4	11	20	45	105	532	717
Nursing, Midwifery and AHP	0	0	0	0	0	0	0	0	0	0	13	13
Office of the Chair and Chief Executive	0	0	0	1	0	0	0	0	0	6	0	7
Office of the Medical Director	0	0	0	0	0	0	0	0	3	1	0	4
Older People and Primary Care	0	0	0	0	0	8	35	129	531	2473	1943	5119
Performance and Reform	0	0	1	0	0	0	0	1	0	2	0	4
Total	1	1	1	1	1	15	51	160	665	2907	4053	7856

2.9 Early Alerts Submitted by the Southern Health and Social Care Trust

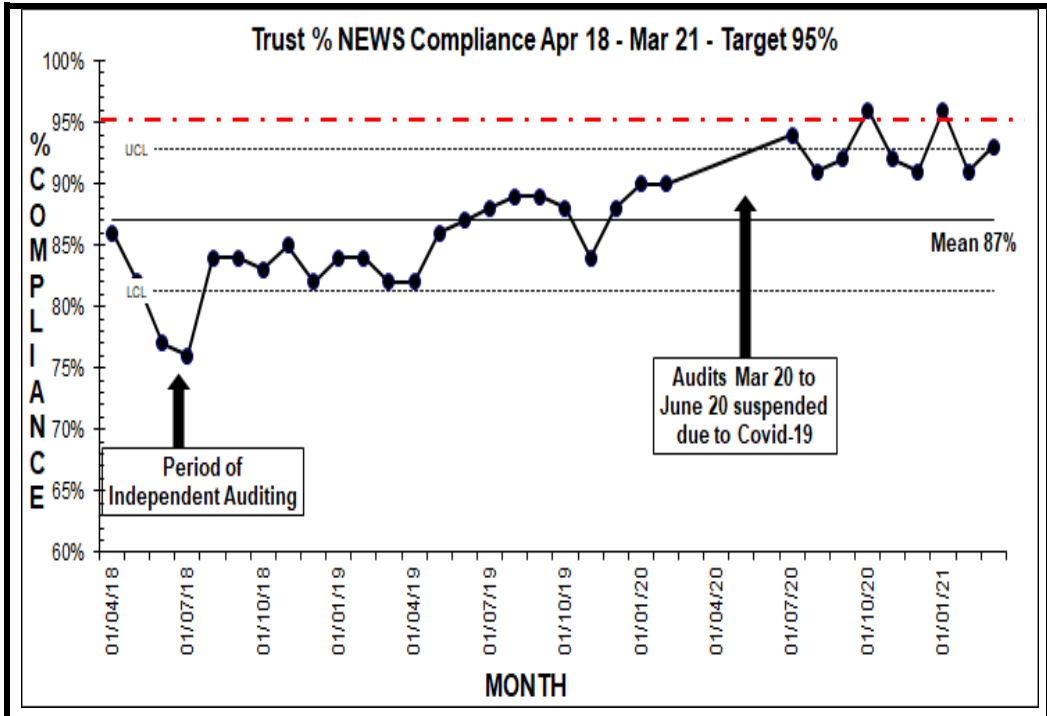
Between 1st April 2021 – 30th June 2021 there has been 42 (22 in relation to GP OOH) Early Alerts submitted to the DoH and the HSCB. 38 of these were new alerts; 4 were updates on previously submitted Early Alerts.

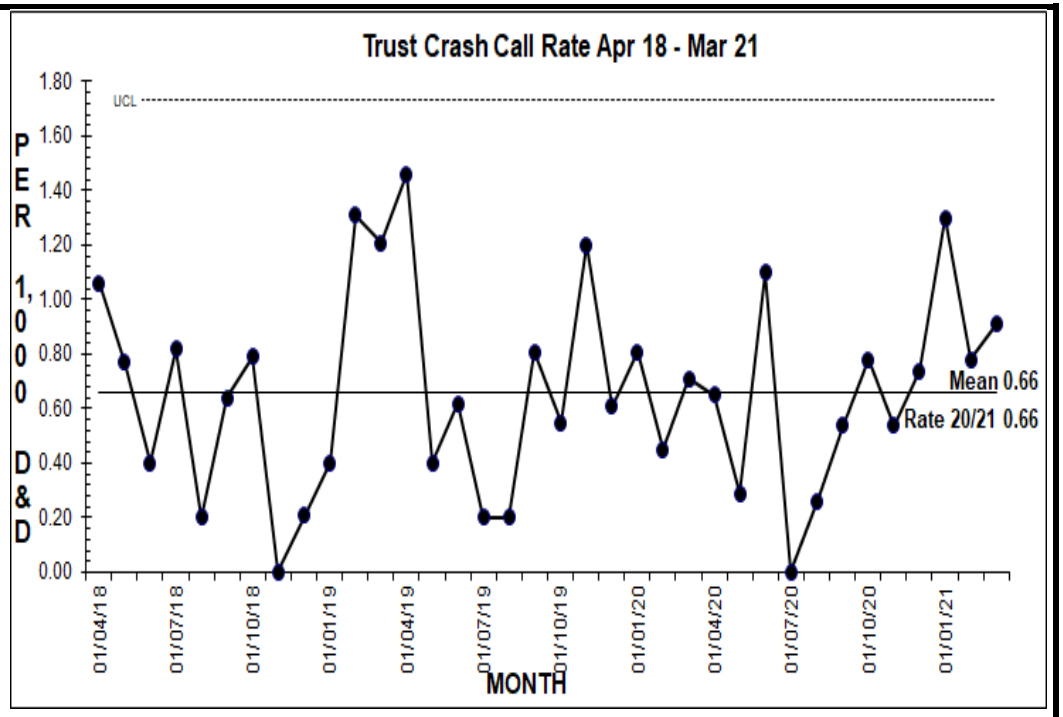
[8] Approval status reporting is for all unapproved incidents (6770@April 2021, 6825@January 2021, 6089 @ 07/11/2020 5107 @ 14/08/2020, 4486@ 27/04/202, 4532 @21/01/20, 4348 @ 15/11/19, 5107 @ 14/09/2020) on Datix Web pre governance committee report.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

3.0 Patient Safety Measures Data – Quarter 4 Jan 2021 → March 2021

3.1. NEWS & Crash Calls[9]



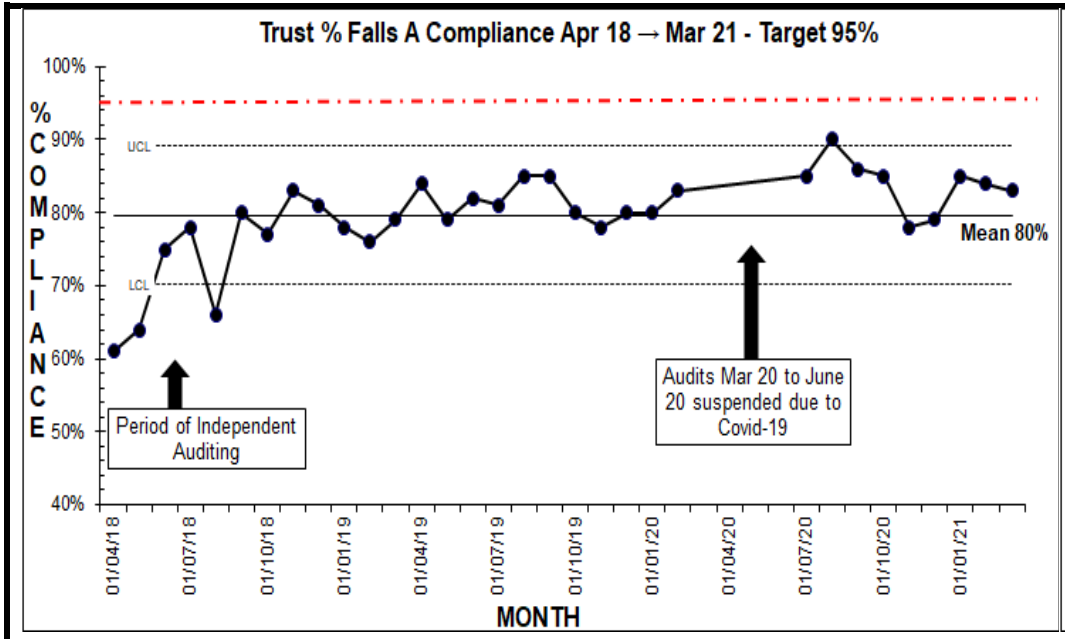


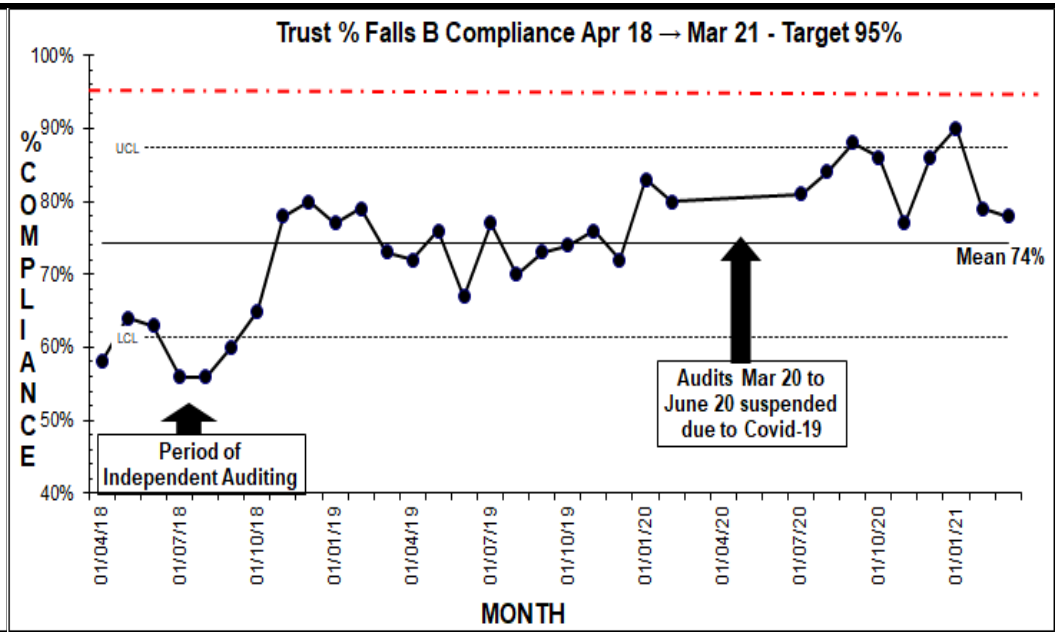
- NEWS – Q1 20/21 (Apr 20 → June 20) Audit was suspended by PHA due to Covid 19
- NEWS Compliance Q4 20/21 (Jan 21 → Mar 21) was **93%,** same as Q3
- Trust Crash Call Rate for 20/21 was **0.66** per 1,000 Deaths & Discharges (**30** Crash Calls) compared to **0.67** per 1,000 Deaths & Discharges (**39** Crash Calls) in 19/20
- Based on the data there has been no significant change in Crash Call Rates. NEWS compliance breached the target & also breached the upper confidence limit in Jan 21

[9] The NEWS Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. March 20 Audit suspended due to Covid-19. Regional Improvement Work on Crash Calls began in 2008, since June 2008 the Trust's Crash Call Rate has fallen significantly from a Baseline of 1.89

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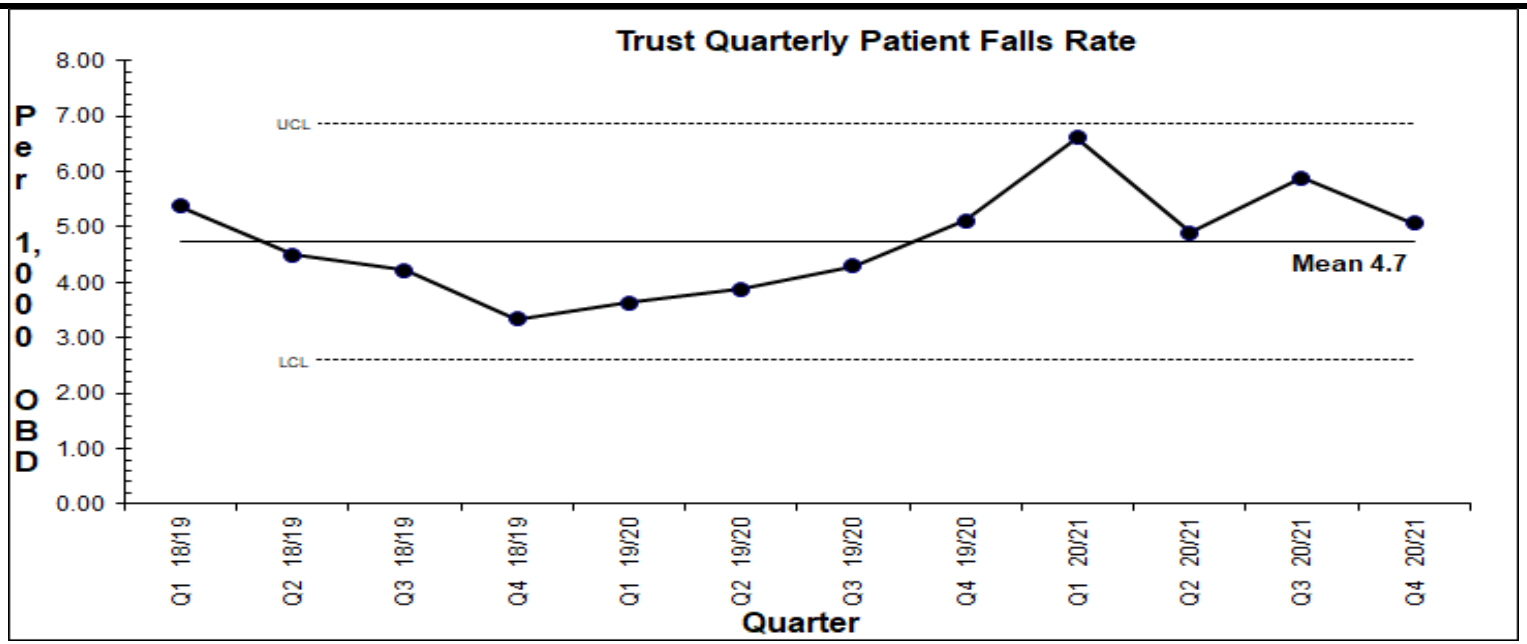
3.2. Patient Falls[10]





[10] The Falls Audits are a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Patient Falls began in 2011. In line with the Region since Apr 18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.

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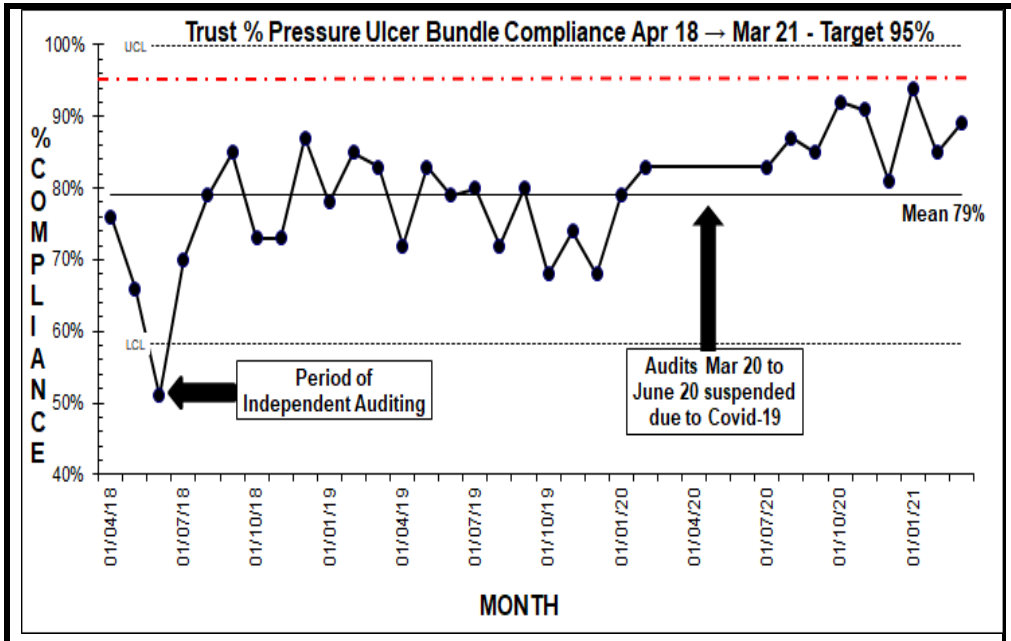
- FallSafe – Q1 20/21 (Apr 20 → June 20) Audits A & B were suspended by PHA due to Covid-19
- FallSafe Bundle A Compliance Audit Q4 (Jan → Mar 21) was **84%**, compared to **81%** in Q3 20/21
- FallSafe Bundle B Compliance Audit Q4 (Jan → Mar 21) was **82%**, compared to **83%** in Q3 20/21

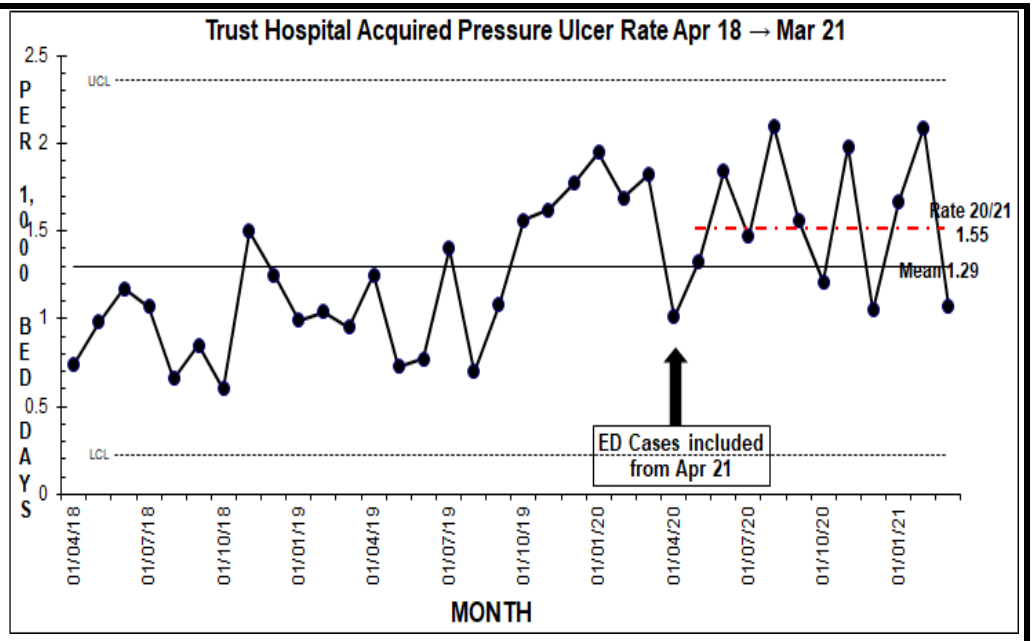
- Patient Falls Rate Q4 20/21 was **5.06** per 1,000 Occupied Bed Days, compared to **5.89** in Q3 20/21
- Patient Moderate & Above Falls Rate Q4 20/21 was **0.19** per 1,000 Occupied Bed Days compared **0.11** in Q3 20/21
- Trust Patient Falls Rate 20/21 was **1,313** (**5.56** per 1,000 Occupied Bed Days) compared to **1,171** (**5.35** per 1,000 Occupied Bed Days) in 19/20
- Of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick **21** wards (**78%**) saw an increase in Patient Falls Rates in 20/21 compared to the same period 19/20.

- There has been no significant change in the falls rate, however there has been significant improvement in compliance with Falls Bundle B with 1 upper confidence limit breaches in Q4

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3.3. Hospital Acquired Pressure Ulcers[11]



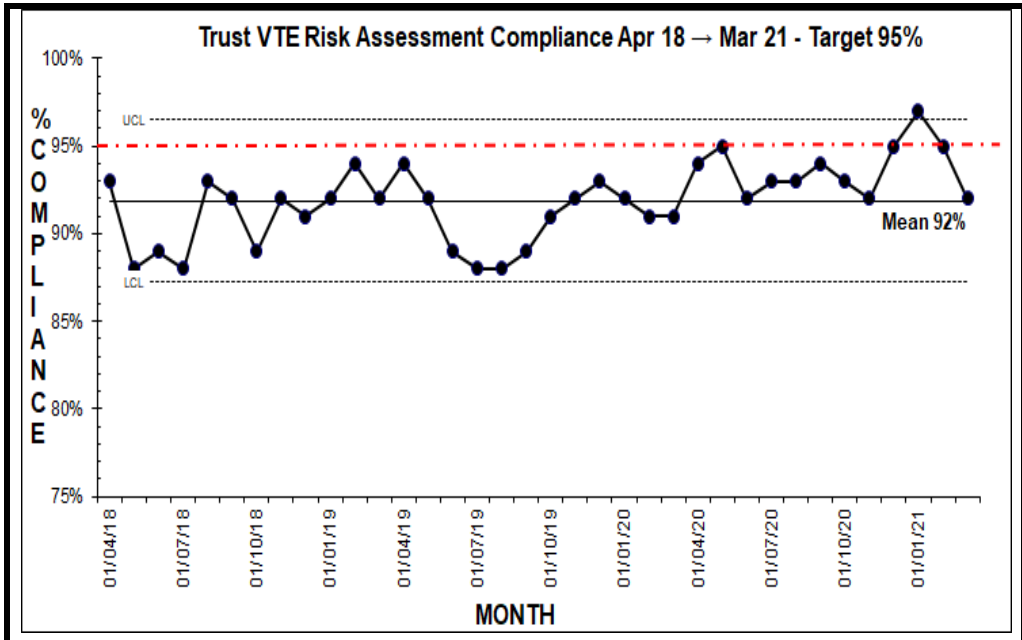


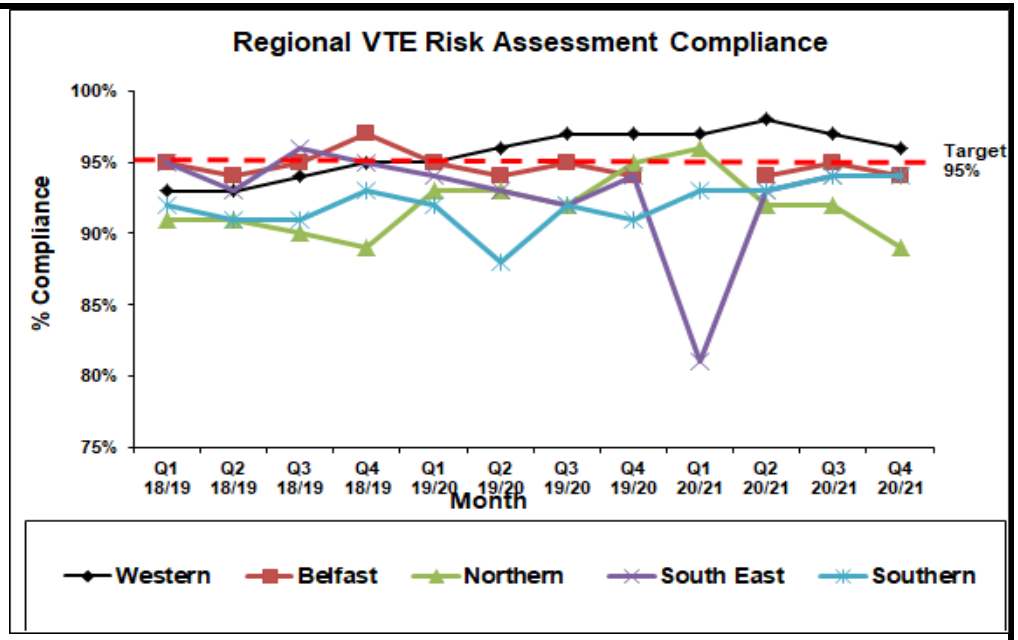
- Pressure Ulcer Audit – Q1 20/21 (Apr 20 → June 20) was suspended by PHA due to Covid-19
- Pressure Ulcer Bundle Compliance Audit Q4 (Jan → Mar 21) was **89%**, same as Q3
- From Apr 20 acquired cases in ED's are included as per Regional Direction
- In 20/21 **33** (**11%**) Stage 3 & above avoidable Pressure Ulcers were noted, compared to **35** (**12%**) in 19/20
- Themes/shared learning arising out of avoidable Post Incident Reviews are fed back to Ward Managers, via Lead Nurses
- There has been no significant change in Bundle compliance in Q4 20/21, however the incident rate has increased compared to 19/20, which is partly due to including cases in the ED's of CAH & DHH

[11] The Pressure Ulcer Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Pressure Ulcers began 2011. A number of pro-active initiatives have subsequently taken place i.e. the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan. The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on ward acquired pressure ulcers to determine those which were avoidable.

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3.4. Venous Thromboembolism (VTE) Risk Assessment Compliance[12]





- Trust compliance in Q4 20/21 was **94%**, same as Q3 20/21
- Trust compliance 20/21 **94%**
- Risk Assessment Compliance breached the target in Jan 21 & Feb 21 & also breached the upper confidence limit in Jan 21
- Performance is reported to Acute Governance on a monthly basis, where Wards with a decline in compliance is highlighted
- Audits not undertaken in Q1 20/21 in the Belfast Trust & Q4 20/21 in the South East Trust due to Covid-19

[12] Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009. All Trust's now use a Regional Risk Assessment Tool. For the past number of years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%. All Trusts have seen an increase in compliance since measurement began in April 2013.

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4.0. Service User Formal Complaints

4.1 Complaints received

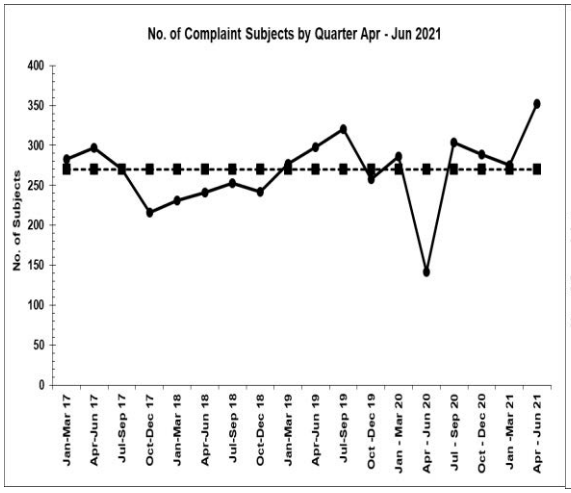
Regionally complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects.

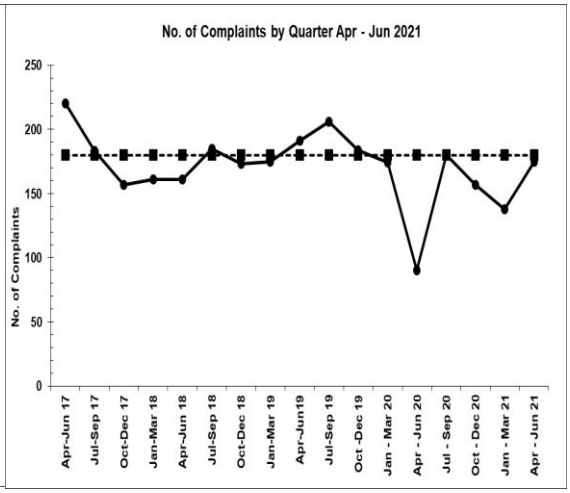
- April – June 2021 175 complaints received
- January – March 2021: 138 complaints received
- October – December 2020: 157 complaints received
- July – September 2020: 180 complaints received
- April – June 2020: 90 complaints received
- January – March 2020 174 complaints received

Although it appears there has been an increase in the number of complaints received this quarter, numbers are returning to similar prior to the COVID-19 pandemic.

This period **175 complaints** were received (**27% increase** on Jan - Mar 21). The 175 complaints contained **352 complaint subjects** (**an increase of 28%**).

Figures 8.0 & 9.0 below show complaint and complaint subject levels





4.2 Complaint Subjects

These have been ranked for the period Apr - Jun 2021, with previous quarter comparisons.

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Table 16.0 below details the top 10 complaint subjects by % share of the 352 subject total. It also compares the level of those complaint subjects against previous quarters.

Apr - Jun 2021					
Complaint Subject	Jul Sep 20	Oct Dec 20	Jan Mar 21	Apr Jun 21	Subject %
Communication / Information	79	84	67	98	28%
Quality of Treatment & Care	47	54	48	65	18%
Staff Attitude/Behaviour	54	54	53	59	17%
Professional Assessment of Need	35	22	26	43	12%
Clinical Diagnosis	7	10	14	11	3%
Property/Expenses /Finances	4	6	5	9	3%
*Waiting Times, Outpatient Departments	2	3	2	8	2%
Waiting Times, A&E Departments	2	1	1	7	2%
**x3 Subjects = 6	23	22	19	18	5%
***Confidentiality	2	2	4	5	1%

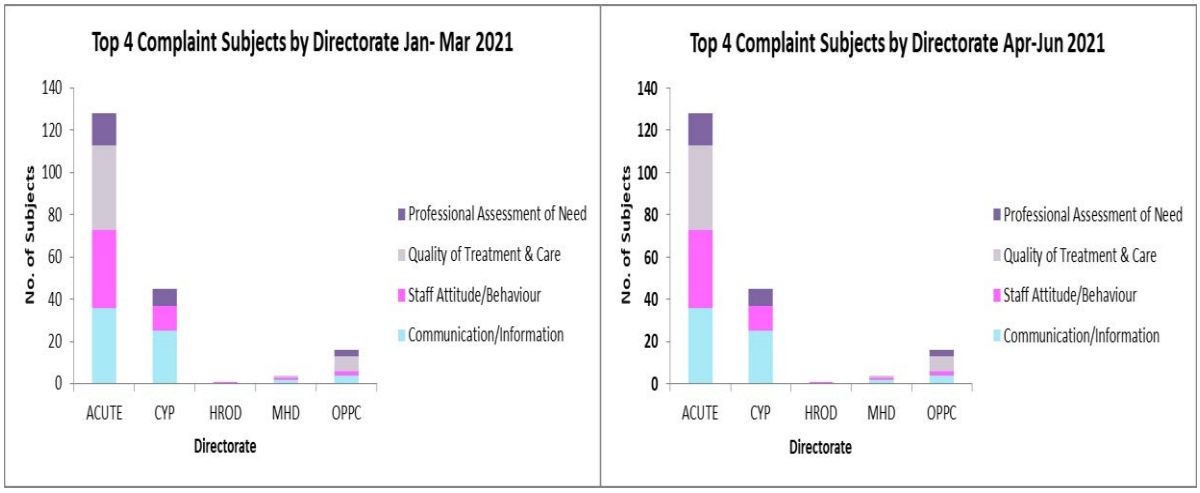
*First time since Dec 2019 that Waiting times in Outpatients has occurred in the top 10. The majority of these complaints were received into IMWH, Surgery and Elective Care and 1 for Childrens Health.

**Three subjects appeared on 6 occasions within the time period April – June 2021 sharing 9th place. These subjects were Waiting List, Delay/Cancellation Outpatient Appointments, Quantity of Treatment & Care and Policy/Commercial Decisions.

***Confidentiality last appeared in the top 10 in April – June 2020. These 5 complaint subjects were received into the Acute and MHD Directorates, covering 4 complaints.

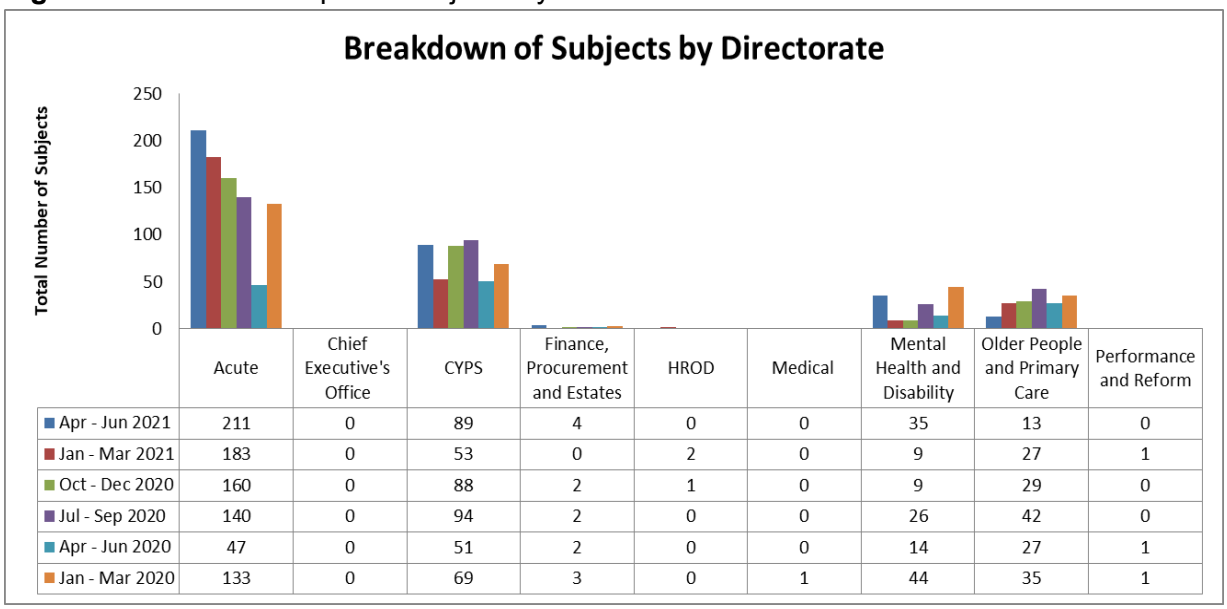
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A further drill down of the **'top 4'** areas shows they covered 75% of the quarter's 352 complaint subjects. These 4 subject areas are split across the 5 operational service directorates as shown in **Figs 10.0 & 11.0**, compared to previous Qtr.



4.3 Complaints % by Directorate[13]

Figure 12.0 - Total Complaint Subjects by Directorate since March 2020.



	Acute	Chief Executive's Office	CYPS	Finance, Procurement and Estates	HROD	Medical	Mental Health and Disability	Older People and Primary Care	Performance and Reform
Apr - Jun 2021	211	0	89	4	0	0	35	13	0
Jan - Mar 2021	183	0	53	0	2	0	9	27	1
Oct - Dec 2020	160	0	88	2	1	0	9	29	0
Jul - Sep 2020	140	0	94	2	0	0	26	42	0
Apr - Jun 2020	47	0	51	2	0	0	14	27	1
Jan - Mar 2020	133	0	69	3	0	1	44	35	1

4.4 Complaint Response

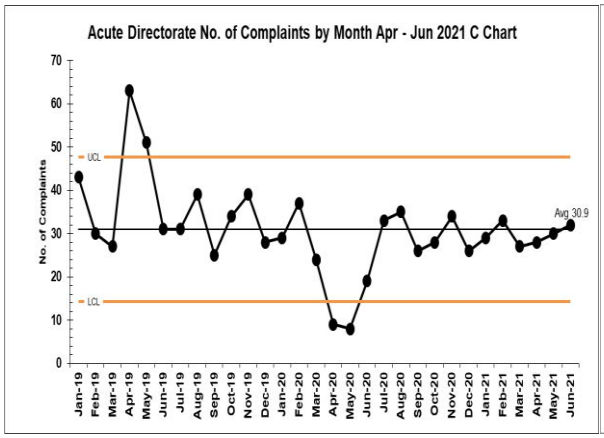
The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days.

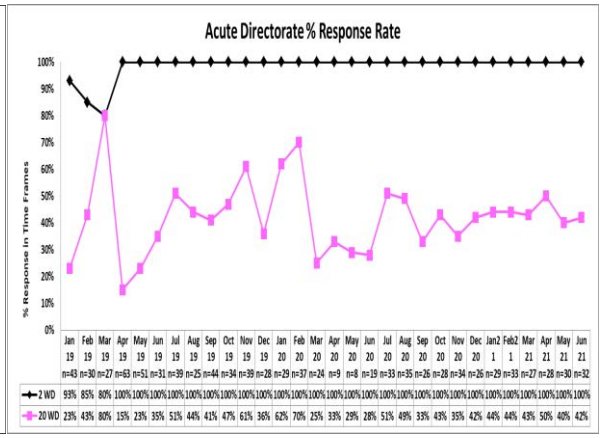
The information in the following charts (collectively **figure 13**) details the number of complaints by directorate, the 2 working day acknowledgement and 20 working day response rates

[13] A breakdown by Division is available through the relevant Directorate Governance Team

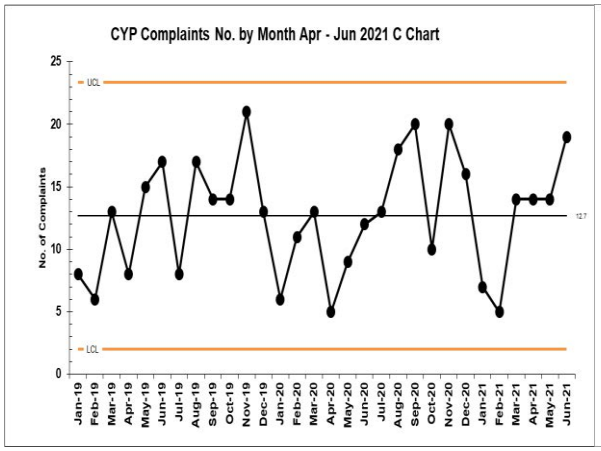
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

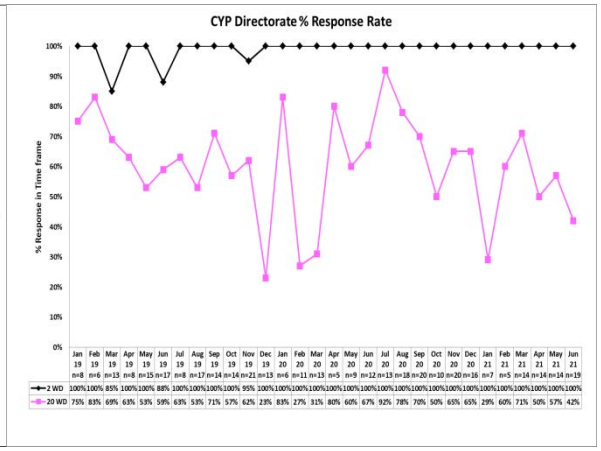
Acute Complaints and Response Times



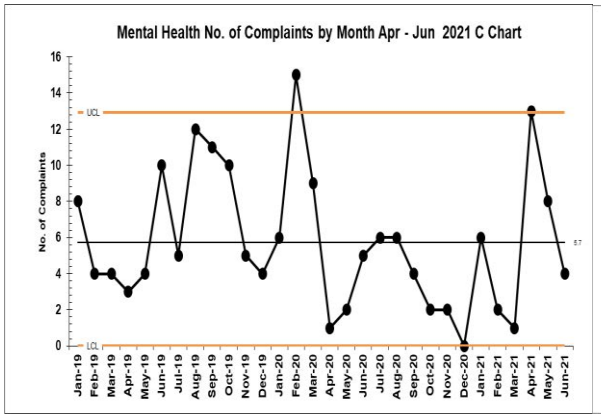


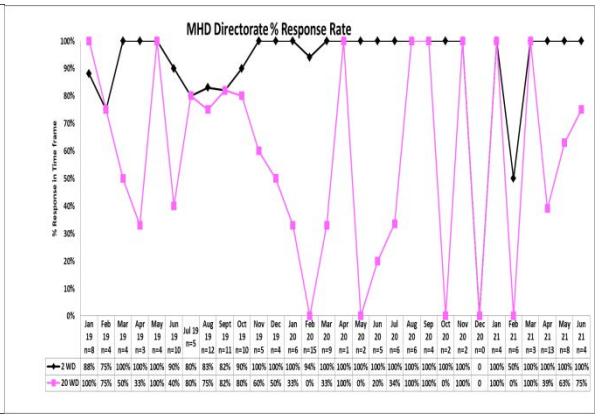
CYPS Complaints and Response Times





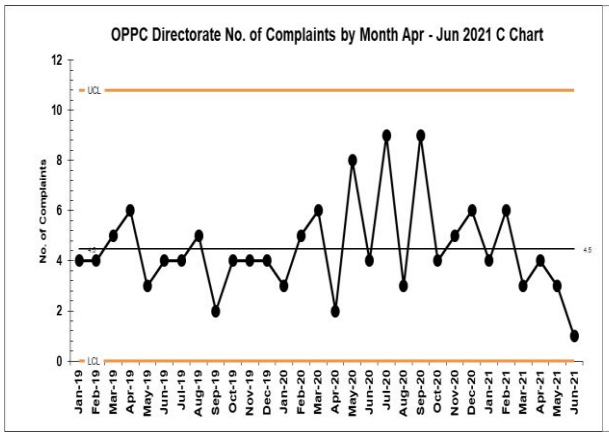
MHD Complaints and Response Times[14]

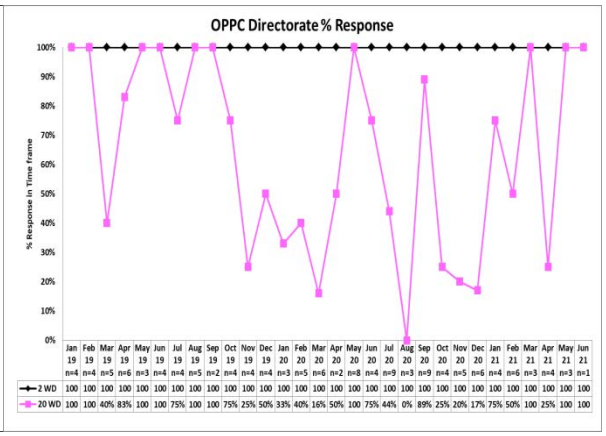




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OPPC Complaints and Response Times





4.5 Independent Sector Providers

The new guidance (2019) in relation to the HSC Complaints Procedure stipulates that complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated. In order to become compliant with this section of the guidance, the governance departments would require additional resources. A meeting is being arranged to discuss all Governance arrangements for the Independent Sector.

4.6 Informal/Enquiries and Local Resolution

Table 17.0 below sets out the informal methods of complaints received for all directorates since July 2019.

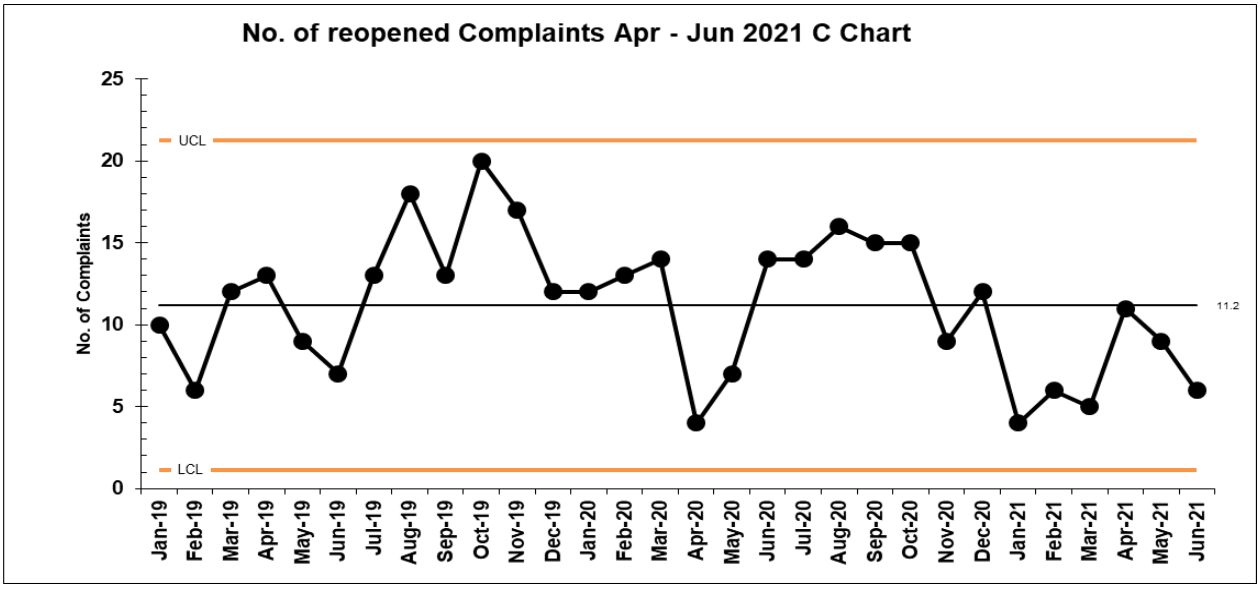
	Total - All Directorates							
Resolution Stage / Method	July-Sep 19	Oct - Dec 19	Jan - Mar 20	Apr - Jun 20	Jul-Sep 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21
Awaiting consent	12	33	12	10	15	4	7	18
Enquiry	148	66	98	63	143	132	104	119
Informal HSC Complaint	110	50	58	35	30	47	46	61
Resolved at Point of Service Delivery	16	2	7	3	7	3	4	15
Redirected	12	8	6	10	4	7	4	2
COVID 19 Enquiry			16	61	12	26	28	5
Totals	298	159	197	182	211	219	193	220

4.7 Complaints – Re-opened

Apr – Jun 2021 saw 26 complaints re-opened. The line graph below shows the number of Reopened complaints since January 2019.

Figure 14

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4.8 Complaints - Response Audit

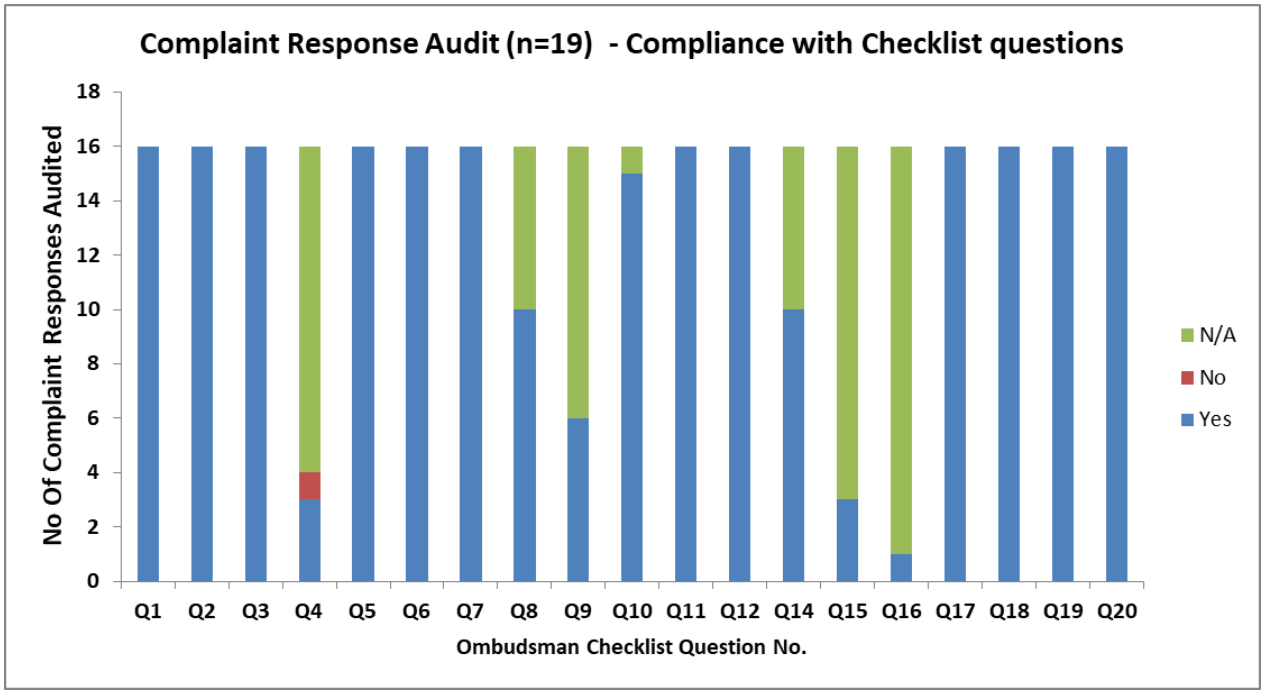
A total of 175 complaints were received from April to June 2021, a response audit was carried out on 16 of these complaints using the regionally agreed 'Checklist for Preparing Draft Responses to Complaints'. The checklist takes into consideration the Ombudsman's Principles of Good Complaint Handling[15].

Fig 15.0 – Response Audit Results and Commentary

All complaints audited were fully understood and contained a polite opening to the letter and provided a short summary of the complaint issues. All of the responses reflected the Trust values and were very understandable and expressed regret were applicable. One complaint that experienced a bereavement did not include condolences in the response. The Trust had offered a remedy to a complainant in one response and a meeting to discuss the outcome of a complaint investigation was offered to one of the complainants. All of the responses advised the complainant of any changes/improvements that had taken place as a result of their complaint were applicable.

[15] Question 13 has been excluded from the chart above as there is no way of detecting from reviewing the response whether the accuracy of the facts was double checked.

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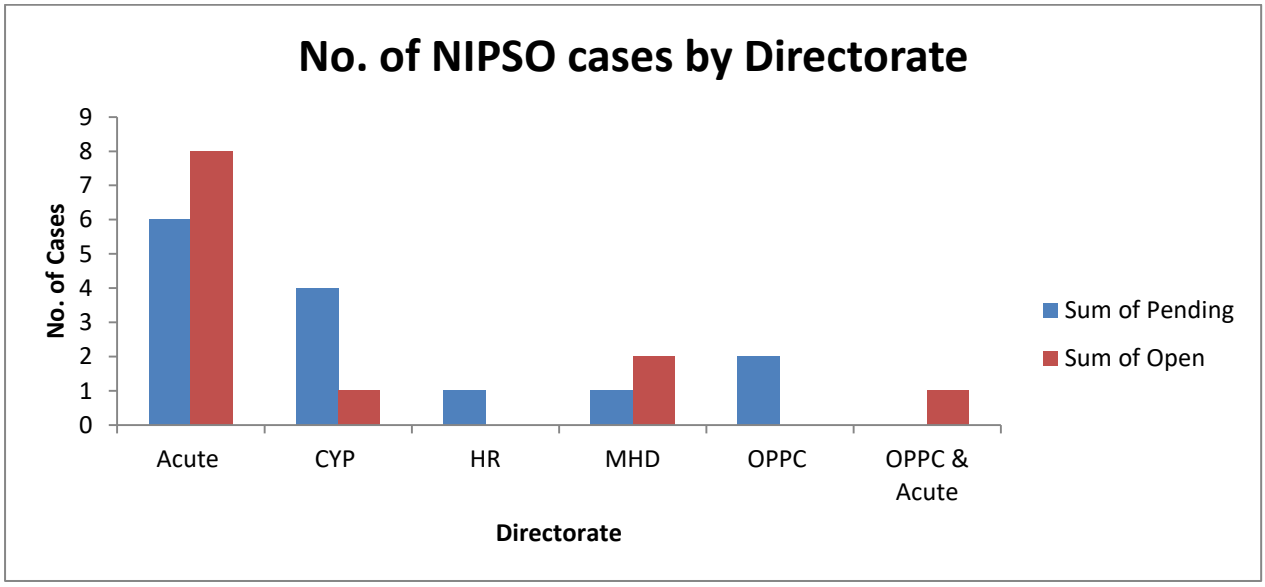


4.9 Ombudsman Cases

Apr - Jun 2021, SHSCT received 7 requests for information from the Ombudsman's Office. 6 of these cases are currently pending and 1 has been opened.

At present there are 12 open Ombudsman cases and 14 pending cases.

Figure 16 below shows a breakdown across the Directorates.



Three reports were received and the Recommendations from these have been circulated within the relevant Directorate for action. The three recommendations provided involved communication - GPs communicating plans to their patients, Record keeping - importance of ensuring that Diagnostic Assessment Reports reflect the information that is considered when reaching a diagnostic decisions, and the third related to record keeping also but in reference

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to patient identity.

4.10 Health Care Complaint Analysis Tool

As an action from a previous Governance Committee meeting it was agreed that the HCAT tool would be used to analyse all formal complaints received into the Service User Feedback Team from the 1st June 2020. The report for complaints received April – June can be found at Appendix 1.

As previously noted in the last Governance paper, as the data collection continues to grow, greater in-depth analysis will facilitate learning for directorates to be able to focus upon and evidence any improvements to services they may make.

5.0 Service User Compliments

Business Services Organisation (BSO) is the HSC organisation that hosts the compliments websites and servers, on which SHSCT compliment data is stored. BSO is now providing compliment information to HSCTs.

Table 18.0 below shows the compliments received into the Trust in the period. Only written compliments are reported to the DOH (verbal compliments, confectionary etc. are not included) and only compliments from service users are included (compliments from staff are not included).

Table 18.0 – Compliments Received by Subject and Method Apr - Jun 2021 – There has been a slight decrease since previous quarter.

Apr - Jun

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	176	14	1	21	3	0	104	**319**
Staff Attitude & Behaviour	173	22	4	21	5	0	122	**347**
Information & Communication	92	12	2	15	0	0	98	**219**
Environment	75	4	2	13	0	0	11	**105**
Other	0	0	0	1	0	0	0	**1**
Total Compliments	**516**	**52**	**9**	**71**	**8**	**0**	**335**	**991**

Previous Quarter

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	187	40	7	6	2	0	94	**336**
Staff Attitude & Behaviour	170	55	10	8	3	0	173	**419**
Information & Communication	107	15	5	3	1	0	82	**213**

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Environment	92	7	2	1	0	0	34	**136**
Other	0	1	0	0	0	0	0	**1**
Total Compliments	**556**	**118**	**24**	**18**	**6**	**0**	**383**	**1105**

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Southern Health and Social Care Trust

Quality Care - for you, with you

Appendix 1

Healthcare Complaints Analysis Tool

April - June 2021

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1. Executive Summary

The Healthcare Complaints Analysis Tool (HCAT) was used to analyse 3 month's (April, May and June 2021) of complaints received by the Southern Trust. Prior to this a report was compiled for January, February, and March. HCATs purpose will be to continue to support organisational learning by further analysing complaints in an aggregate and objective way. Each complaint will continue to be coded from the complainant's perspective and therefore the issues which could seem minor to a health and social care worker, could feel major to the complainant.

This data analysis will continue to develop and evolve. It remains the Trusts focus to increase learning from complaints from a different perspective in order to continue to gain greater insight, and understanding to allow for an improved and more effective service to all. It should be noted that the HCAT system was developed for a hospital setting and therefore, has been adapted to take into account the unique structure of the Health and Social Care setting in Northern Ireland.

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2. Benchmark Data

The data for January – March 2021 is used as a benchmark against April – June 2021.

Indicator	Jan - Mar 21	Apr - Jun 21
Number of complaints	129	220
% high and catastrophic harm	15.6%	15.4%
% near misses	4.3%	7.8%
% entry-exit problems	14.3%	9.4%
% systemic problems	49.6%	45.9%
% omission problems	46.8%	43.7%

As noted in previous reports, all complaints received are coded according to the complainant's point of view as opposed to a Health & Social Care perspective. Generally a complaint may have a number of subjects of complaint, severity and at specific stages of care, i.e. admission, procedure and/or discharge

This report provides the Trust with insights on the profile and nature of their service user complaints, evaluated using the Healthcare Complaints Analysis Tool (HCAT) developed by the London School of Economics (LSE). The report begins with an introduction to HCAT and its approach.

3. Introduction to HCAT

Organisations usually analyse complaints in relation to the number received. However, this only provides part of the story. If a Trust receives a high number of complaints, this could signal that poor care is being provided, or conversely it could simply be a product of the complaints process being easier to navigate than in other Trusts. Rather than looking at number of complaints, HCAT facilitates an analysis of complaints by severity, which helps to provide a richer picture. A Trust/ Directorate may have a large number of overall complaints, but if the majority are low severity, this is a positive thing; indeed it can be illustrative of a healthy complaints system where patients and their families feel able to complain about a diverse set of issues because they trust that they will be listened to.

Further to this, the tool is innovative since it;

- is based on a systematic review of the complaints literature, has established high reliability, and a systematic procedure for analysis;
- provides both high-level analytics on Directorate/Trust complaint profiles, and insight on specific areas for local-level learning and improvement;
- facilitates benchmarking (e.g. comparing the profiles of Trusts in terms of complaint severity, identifying outliers).

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The Mental Health and Learning Disability directorate, having reviewed the HCAT information for the Southern Trust are using the findings as an 'early alert' and recognising an opportunity to listen to service users with regards to communication. It has been noted that some complaints received for the directorate highlight how service users' carers and families are communicated with, while still respecting the rights and wishes of the service users. A project group is being convened to explore viable options as to how best to manage expectations of service users' carers and families while supporting them in what can be very challenging situations. The mental health peer advocate will form part of this group once a clear project aim has been agreed.

The Trust will continue to review the data and the themes that arise from the HCAT analysis. As the volume of this increases, the value of this analysis becomes greater and opportunities to improve engagement with our service users, carers, families and others strengthens.

4. Method

Usable formal complaints were analysed from the Southern Trust for the last quarter, April, May and June 2021. We will continue to explore how HCAT can be used to identify areas of improvement and learning. It also will allow learning to be developed with the service user's perspective and also provide insight into potential issues at a lower level of harm before they turn into a more serious issue.

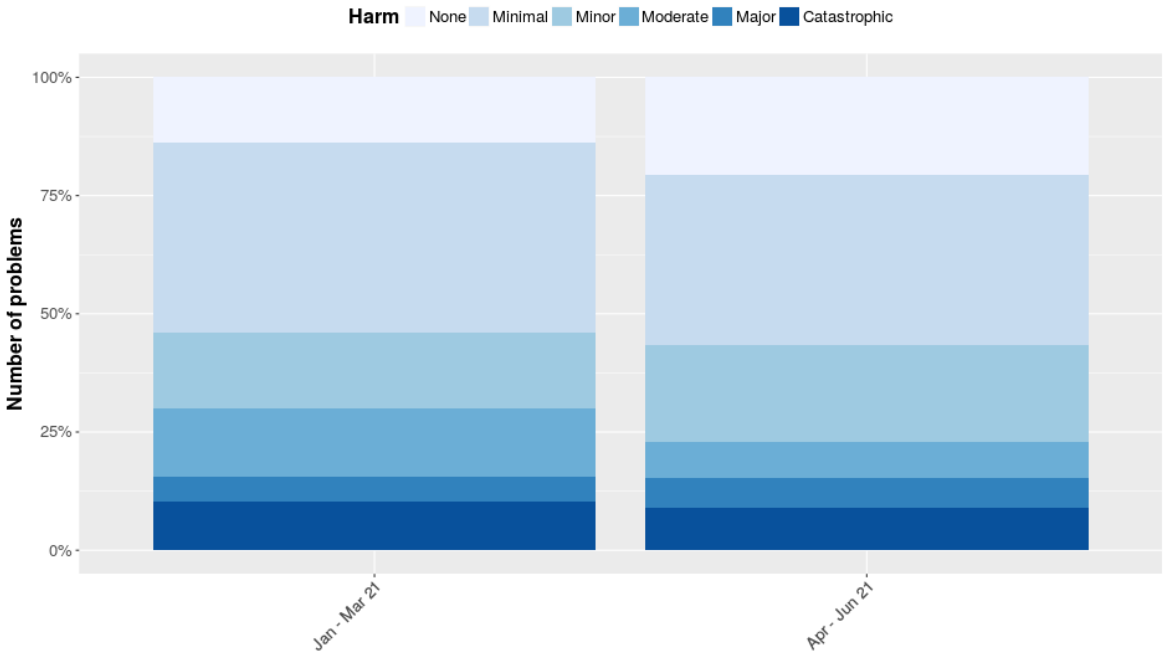
More information on how complaints were analysed, the different components of HCAT (e.g. severity and how this interacts with patient harm) can be found in Appendix 1. It should be noted that in line with HCAT, one complaint can have multiple problems, stages and severity. To assist with theming the complaints, there are also 'sub problems' which are categorised by key words.

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Results of April – May 2021 Data Collection Severity by Harm

A high severity complaint is a complaint letter that has at least one 'high severity' problem reported within it. High severity problems reflect the most extreme types of issues relating to each problem category (please see Appendix 1 for further details).

Chart 1 – Severity by Harm



In this quarter we can see the number moderate severity of complaints has decreased significantly while the number of minor has increased. The increase in low severity complaints may indicate that patients and their representatives may be more willing to raise lower level concerns for the Trust to act upon over the period of April - June 2021. Both no and minor severity of harm complaints has continued to increase which is encouraging as it may indicate that Service Users are able to access the Service User Feedback system more readily even to raise the smaller issues that identify areas for improvement. There has been little change in catastrophic severity complaints compared to the last quarter but are still low in comparison to other stages.

Stages of Care

Within the Southern Trust coding form, “Care on Ward” was changed to “Care” to reflect the different settings in which a complainant could receive care and therefore, feel the need to provide feedback about same.

This bar chart shows the stages at which problems occur, including the amount of harm reported at each stage. This is useful for identifying the stages of care where patients are reporting the most harm. The April – June 2021 complaints reporting, high and catastrophic harm remains relatively low, which reflects positively for the Trust.

Coding is based on the complainant’s perception and judgement of problem/s. It would appear that when a complainant has made a complaint about multiple stages of care, the Trust should focus its improvements on the patient pathway to ensure consistent, high quality care throughout their journey.

Chart 2 – Harm by Stage

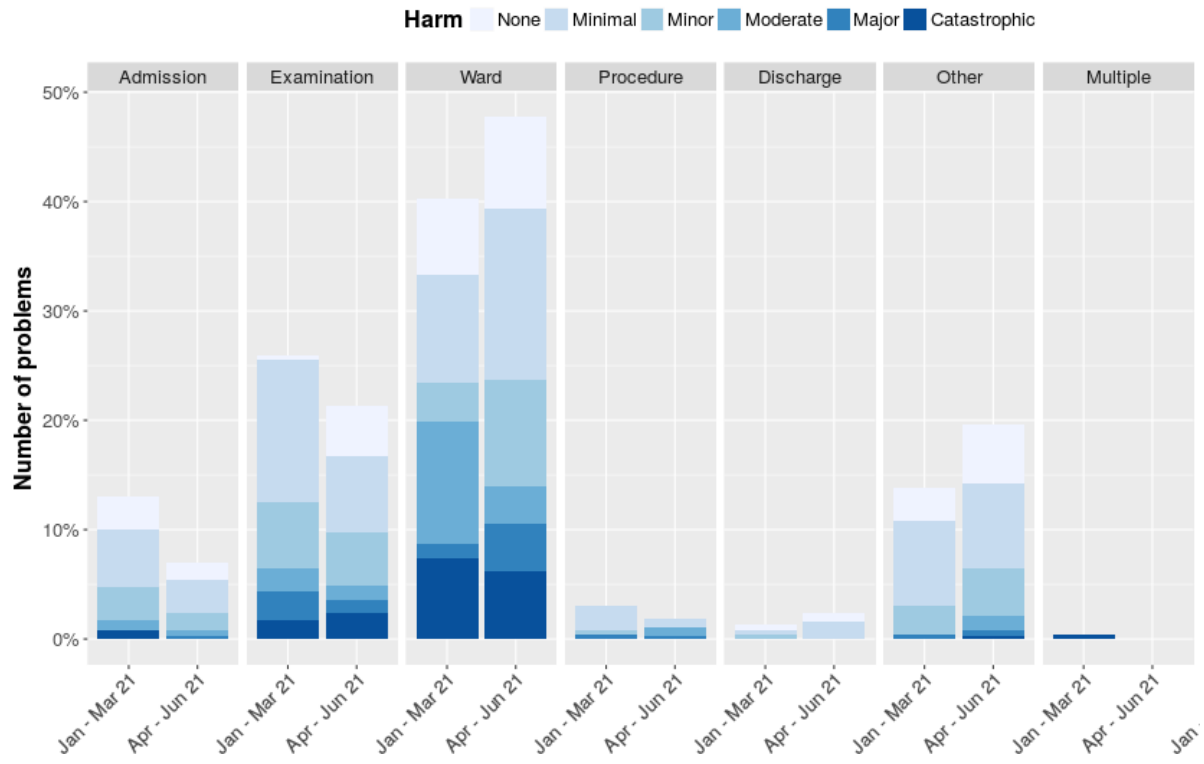


Chart 2 highlights that there is minimal harm being reported with regards to the admission, in comparison to the previous quarter there has been a significant increase in harm during the Service Users care stage and other (other representing Finance/Information Governance) that do not fall into other domains but also a significant decrease in issues at the Admission, Examination and Procedure stages within the Trust.

Near-Miss by Stage

Near-misses are important for identifying potential future problems and processes of error recovery. Moving forward additional data will allow for trends to be identified and learnt from assisting with identifying areas for improvement and where there have been improvements made.

Chart 3 – Near Miss by Stage

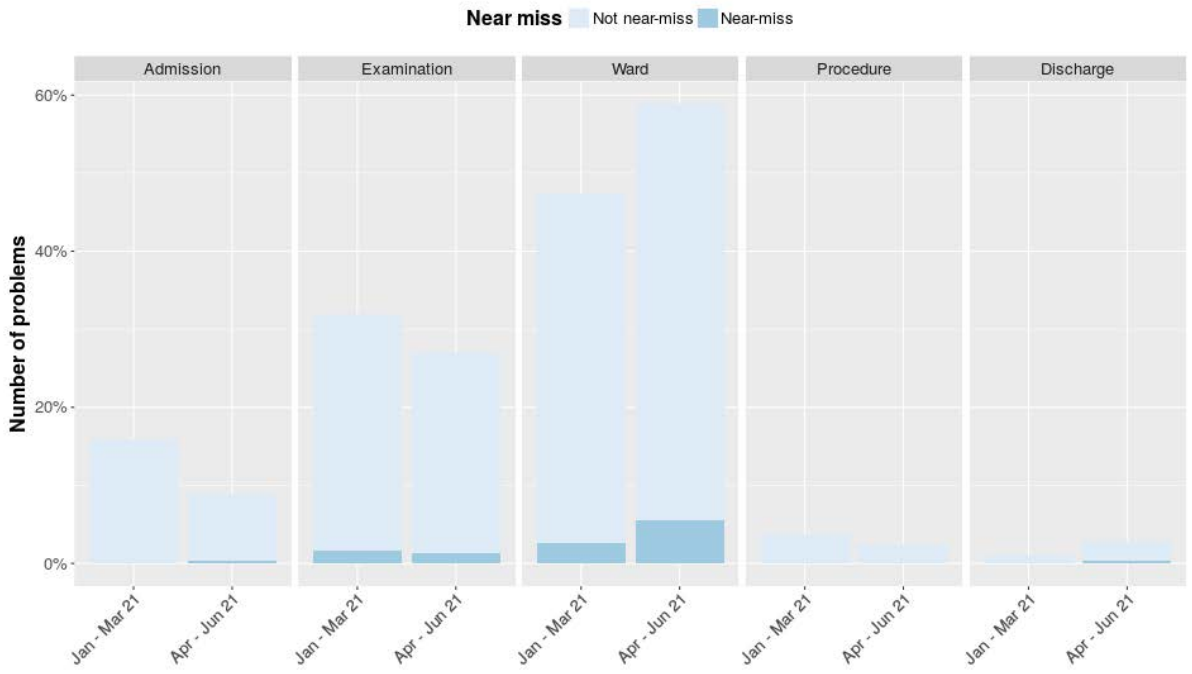


Chart 3 shows the stages at which near-misses occur. Near-misses are important for identifying potential future problems and processes of error recovery. The evidence provided for April - June 2021 suggests that Trust improvements may have been made within the patient's admission, examination/ assessment stage as the level of near misses has decreased significantly. Though there has been a marked increase in near misses at the Care stage. As we continue to use HCAT we can identify patterns and areas of concern should patients continue to complain at specific stages of their journey within the Trust, this would indicate that work needs to be done to improve the Service Users experience and prevent lower levels of harm becoming more serious.

Categories of Harm

Chart 4 – Harm Categories

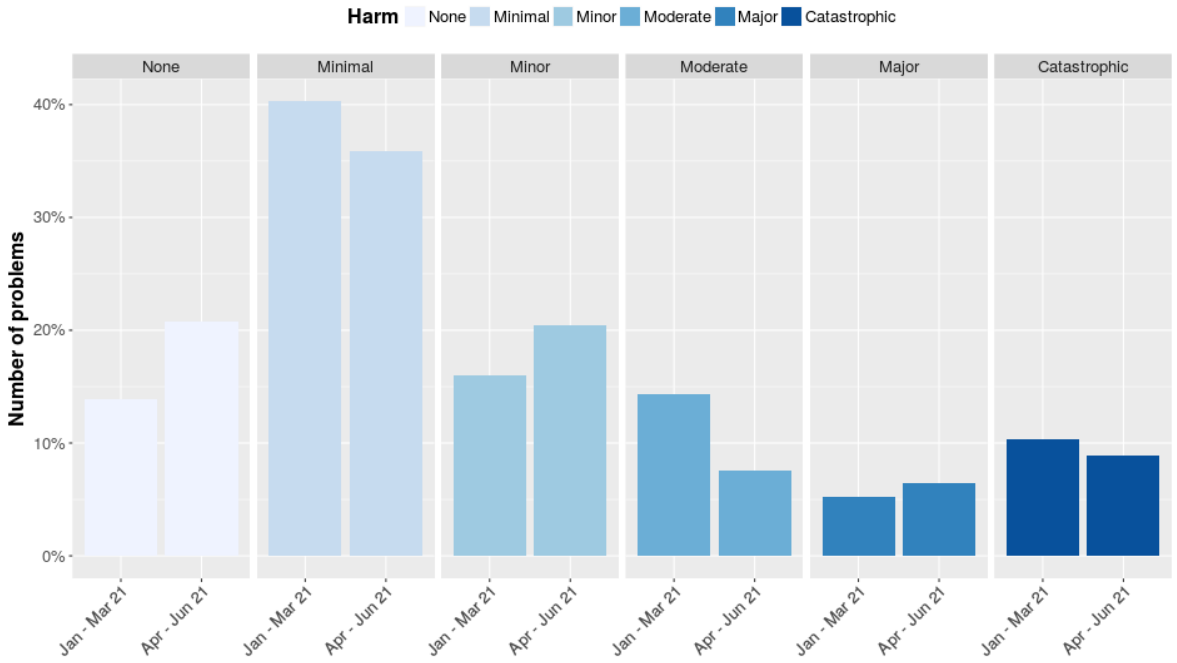


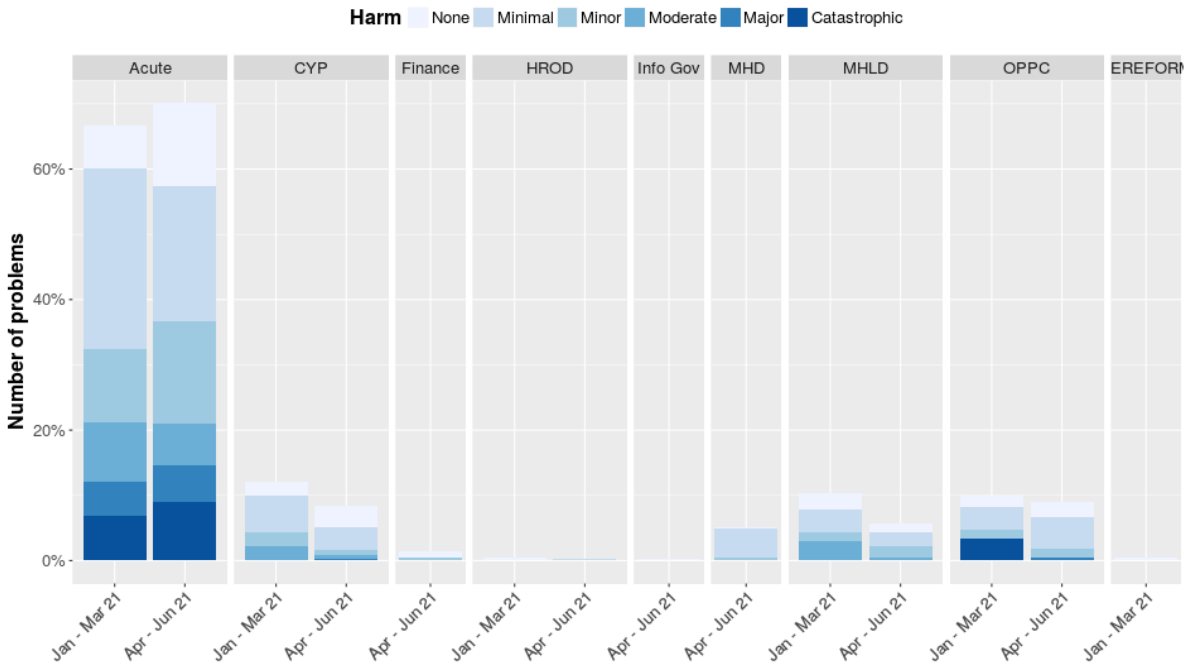
Chart 4 above shows that most feedback was categorised as having caused minimal harm which is positive. Overall from the last quarter there has been a reduction in Minimal, Moderate harm, however we see there has been an increase in minor harm. In total for this quarter there were 9 catastrophic incidents within the Acute Directorate. There were no themes here to identify as these complaints related to a number of domains such as Quality of Care, Safety, and Institution. All also varied in reasons for complaints such as delay in appointments, lack of communication and a hospital acquired infection. The majority of catastrophic occurred during the Service Users stage of care and examination.

Harm According to Directorate

Chart 5 conveys that the majority of complaints remain within the Acute Directorate, followed by, OPPC, Children's Services and Mental Health and Learning Disability. Smaller numbers were received with regards to the lesser "front facing" directorates such as Performance, Finance, HROD and Information Governance.

It should be noted that as we are still experiencing the ongoing pandemic and given that a number of services are still on hold, the Acute Directorate has continued to receive the greatest volume of complaints. It should also be noted that the last two quarters demand on the Acute services continues to be great.

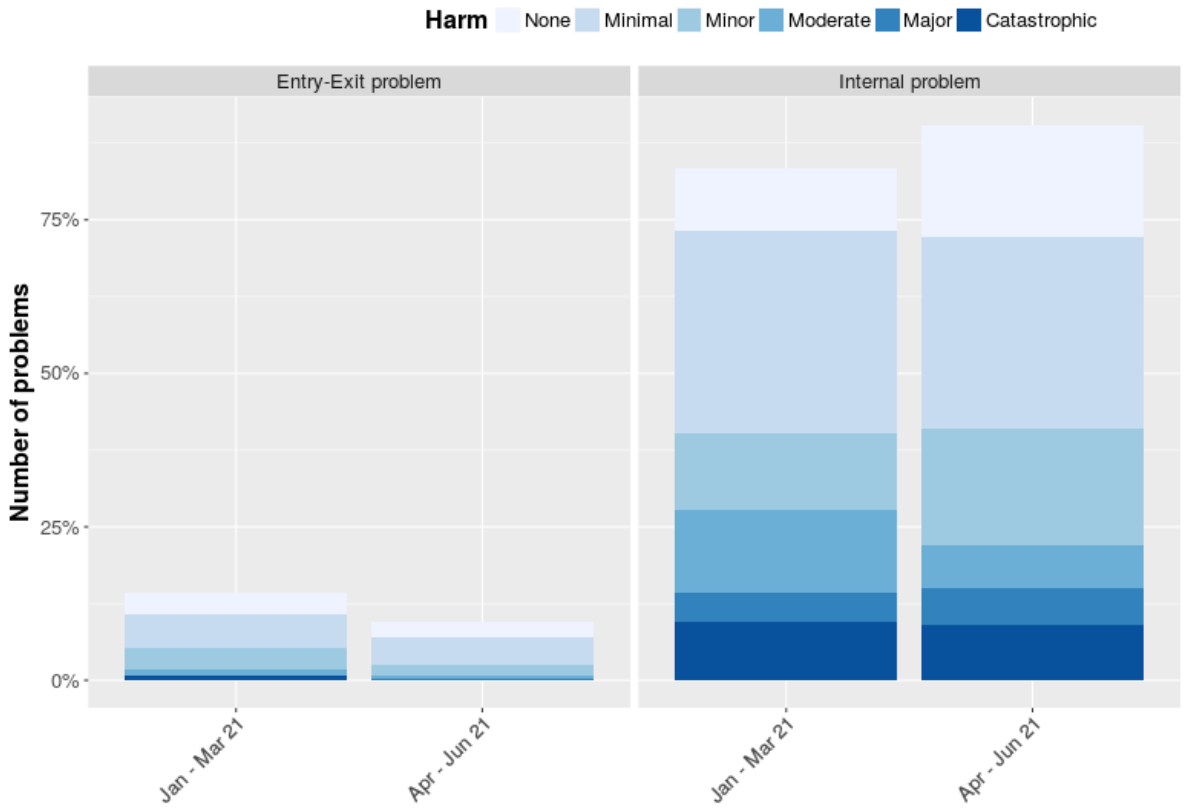
Chart 5 – Harm Categorised by Directorate



Exit-Entry Problems

Chart 6 shows the number of problems that occurred while entering and exiting the healthcare institution, compared to the number of problems that occurred within the institution. The number and type of entry-exit problems can provide information on problems that might be difficult to identify via internal monitoring systems. The 'Jan - Mar 21' data has 14.3% problems reporting entry-exit problems compared to 9.4% for the 'Apr - Jun 21' data.

Chart 6 – Entry-Exit problems

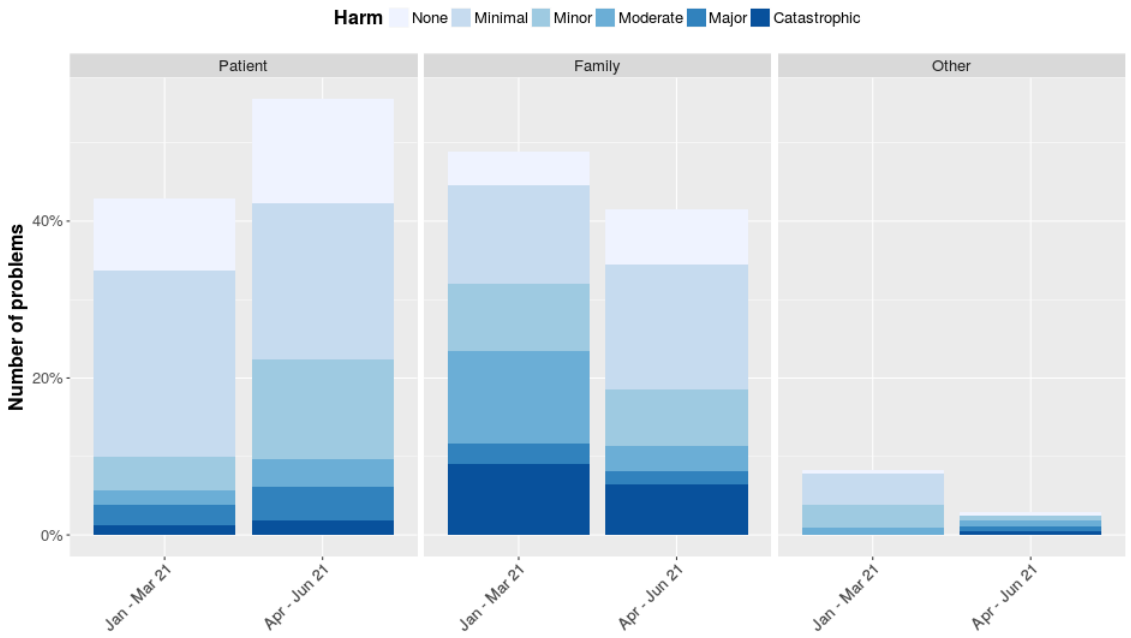


Type of Complainant by Harm

HCAT categorises the type of complainant into three areas, “Family”, “Patient” and “Other. “Patient” within the Southern Trust analysis is inclusive of all service users. “Other” includes elected representatives and third party advocates acting on behalf of service users/ families.

Looking at Chart 7, the high number of “Patient” complainants has remained positive over both quarters and has increased indicating that our Service User Feedback process continues to work well. A high number of complaints had been made by “Family” in the last quarter though this has reduced as well as complaints made by ‘Other’.

Chart 7 – Type of Complainant

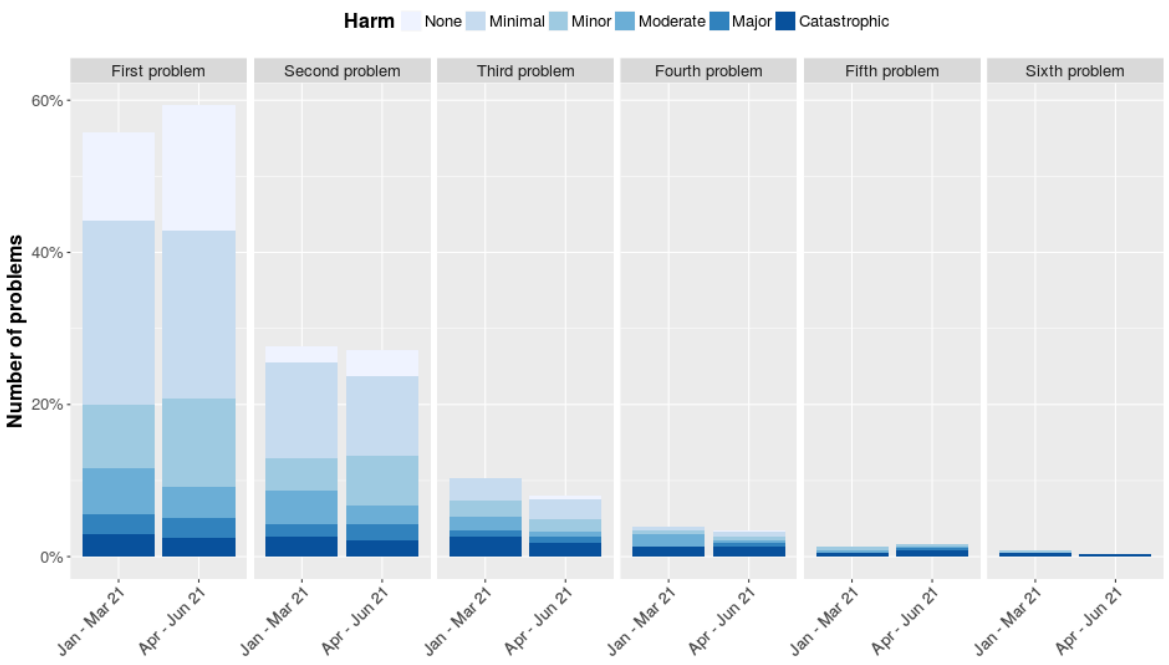


Complaints with Multiple Problems

Chart 8 shows how many complaints have one or more problems. A high number of second, third and fourth problems indicates that the complaints are reporting more complex and systemic issues. In the 'Jan - Mar 21' data 49.6% of problems are systemic compared to 45.9% for the 'Apr - Jun 21' data.

We can see from the chart that compared to the previous quarter there has been a slight increase in first problems and a continued decrease in more complex multiple problems, this may indicate that Service Users may have highlighted just 1 main issue of concern to be addressed.

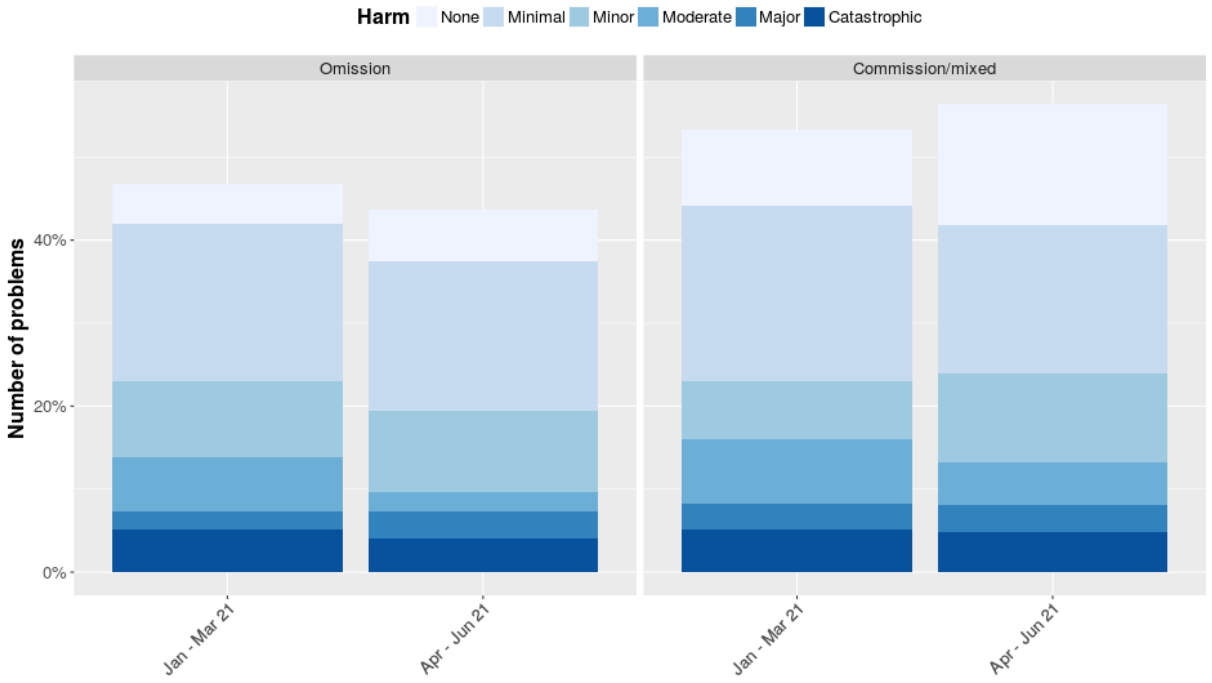
Chart 8 – Systemic Problems



Omission and Commission Errors

Chart 9 provides an indication of the number of problems that are errors of omission and commission. Errors of commission occur when something is done incorrectly. Errors of omission tend to be more difficult to identify because they refer to things not being done. The 'Jan - Mar 21' data has 46.8% problems reporting omission problems compared to 43.7% for the 'Apr - Jun 21' data.

Chart 9 – Omission Problems



Problem Categories

The complaints reviewed identified 4 domains in which there could be learning from, which is further broken down into 8 categories of Quality, Safety, Communication, Listening, Rights, Environment, Institution and other.

The domains include the following categories

- Clinical: Quality and Safety
- Relationship: Listening, Communication and Rights
- Management: Environment and Institutional problems
- Other: Finance, Information Governance

We can see from Chart 10 that complaints within the 4 domains has not altered significantly over the last 2 quarters, going forward as more information is collated the information will become more meaningful in relation to identifying areas of concern and need for improvement. Based on the information already provided however we can identify that the Service Users complaints regarding relationships with staff has reduced but continues to be the highest cause of complaints followed by Management and Clinical issues.

Chart 10 – Harm within each Domain

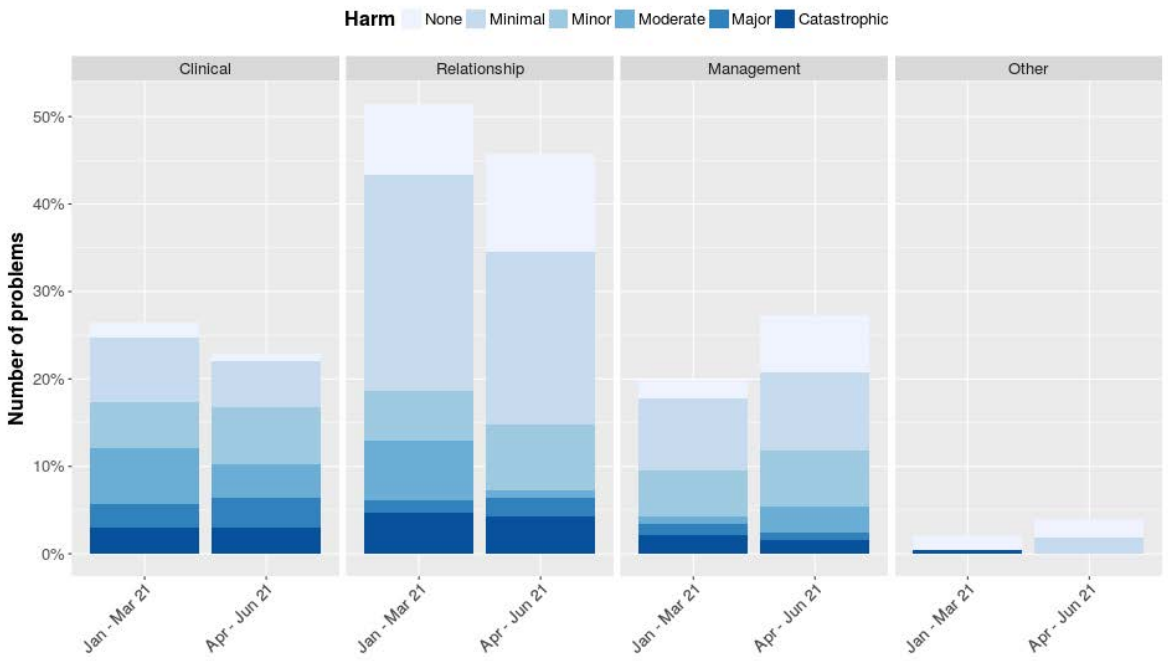
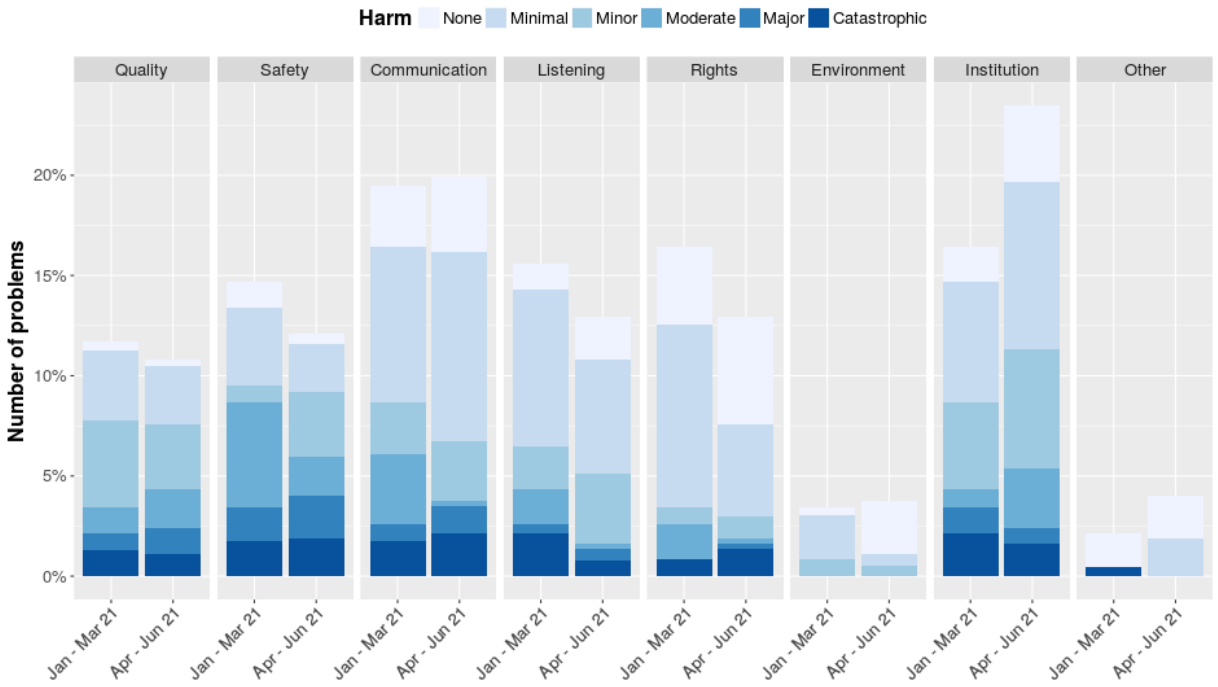


Chart 11– Categories of Problem

Chart 11 shows that there is a decrease issues this quarter in relation to Quality, Safety, Listening and rights. There has been are marked increase in complaints in regards to institution which is the highest issue this quarter, Institutional issues relate to waiting times, accessing care and cancellations.



6. Summary

The HCAT analysis tool will be able to identify areas for improvement as we continue to benchmark against previous quarters - we will begin to identify trends of what we are doing well and what can be improved. As the HCAT is tailored around the Service users point of view, we can see that, although Communication issues have decreased, it remains an area in which the Trust could improve. It is possible also, as we become more focused on Service user Feedback, we will be able to identify further areas of improvement.

7. Conclusion

The motive for using the HCAT reporting tool is to assist in identifying areas for improvement within the Health & Social Care setting, not only can we identify at what stage of the Service Users journey issues are occurring but also the severity from the Service Users perspective. As we continue to use the HCAT and collate more data we can better analyse the information to identify where improvement and learning is required. At the end of the year we can get an overall view of complaints raised and identity trends over the previous 12 months and look at what internal/ external factors may have impacted on both the level and severity of complaints. Each Directorate can choose to use this data for their areas and Quality Improvement.

8. Next Steps

This report is an illustration of how HCAT could be used by the Trust to analyse and learn from their complaints. The report has been limited by the relatively limited timeframe and small number of complaints which has been used. With more extensive data, the report could include:

- *Trend analysis* – illustrating how Directorate's complaint profiles changes over time using longitudinal data, which would allow any improvements to be evaluated.

- *Tailored benchmarking* – in time you could choose a subset of Trusts to be compared against that are more similar to the Trust. Trusts with similar HCAT profiles could also potentially be paired in order to share insights on service improvement and share the learning. Directorates could choose year-on-year comparison to review any improvements made and identify areas which need further explored. At this early stage the process moving forward has many opportunities which need to be tested and reviewed to gage value and purpose.

- *Further granularity* – providing insights on particular directorates, departments or units and in relation to high severity complaints only
- *Direct quotes linked to trends* – the tool facilitates the extraction of specific quotes from a complaint, that are representative of a trend, and which could be used to inform patient stories, for example this data has highlighted institutional issues as being high, having linked in with our Performance Indicators, the Trust has had a rise in waiting times for patients, many of which are likely to have increased as a direct result of COVID-19, which is increasing frustration of those who would have already been waiting for some time. Refocus on supporting services through winter pressures, as well as through the pandemic is ongoing and managing expectations continues to be prevalent.

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Appendix 1: Key HCAT definitions

***Complaint*:** service-user dissatisfaction about healthcare provision that is communicated to the institution and documented within the institution. A complaint can report multiple problems.

***Healthcare Complaints Analysis Tool* (HCAT):** HCAT is a theoretically based and reliable method for coding the subject and severity of problems reported within healthcare complaints. The tool allows for a single complaint to report multiple problems within three domains and seven associated problem categories: clinical (safety and quality), management (environment and institutional), and relationship (communication, listening and patient respect & rights). Within each of these domains, and associated categories, problems are graded on a severity scale from not present (0) to high severity (3). The most severe problems reported within each category, domain and letter are used to provide severity scores for each category, domain and letter. HCAT is free and can be accessed here. There is also a free online training tool that can be accessed here.

***Severity ratings*:** This relates to how severe problems are within a given category. For example, in the problem category of "Quality", a low severity problem would be: *Delay in changing bedding*; a medium severity problem: *patient dressed in dirty clothes*; and a high severity problem: *patient left in own waste*. Severity ratings were developed through analysing a sample of 1000 complaints, and identifying the range of problem types within each problem category. Published research by the LSE shows the severity ratings to be highly reliable. It is notable that severe problems in some categories (e.g. safety, institutional processes) have clear implications for patient outcomes. Severity problems in other categories (e.g. communication) relate more to unexpected or unpleasant experiences that might not have directly caused patient harm, but are highly problematic (from the perspective of patients) nonetheless, and provide insight for learning.

***Harm*:** This relates to the actual harm experienced by patients as a consequence of their complaint. The NHS 2008 "Risk matrix for managers" was used to calculate this, with the following categories being evaluated: N/A. No information on harm is reported; 1. Minimal harm: minimal intervention or treatment required; 2. Minor harm: minor intervention required to ameliorate harm; 3. Moderate harm: significant intervention required to ameliorate harm; 4. Major harm: Service User experienced, or faces, long-term incapacity; 5. Catastrophic harm: death or multiple/permanent injuries.

In terms of the incidences of harm reported in complaints received by SAMPLE HOSPITAL, 10% of complaints described an outcome of major or catastrophic harm (below the average of 14%). 32% of complaints described an outcome of minor or moderate harm. The remainder reported near misses, or issues around management and relationships. Problems that have high severity but do not result in harm include: malfunction of key medical equipment, inability to access care, mix-up of patient notes, ignoring patient in distress, breaching confidentiality, patient provided with wrong test results, not obtaining consent, disrespect for deceased patient, and patient humiliation.

Harm and severity have a moderate association (Cramer's V = .341, $p < .001$). This association is driven mainly by Clinical Severity (Cramer's V = .351), and weaker for

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Management Severity (Cramer's V = .22) and Relationship Severity (Cramer's V = .219).

***Hospital profiles*:** Hospital profiles for complaint severity were calculated by considering the severity of all the complaints reported within the given hospital's sample of complaints, and calculating the proportion of complaints that were i) low severity, ii) medium severity, and iii) high severity. This was also done for complaints referring to different types of problems (e.g. safety), stages of care, and staff groups. We focus on proportions, and not raw numbers of complaints (or complaints per admissions), because receiving a high number of complaints can indicate either i) systemic problems in patient care, or ii) a healthy complaint system where patients and their families raise a diverse set of issues (e.g. low severity) because they know they will be listened to. Analysing the severity of complaints (and what they refer to) allows for a more precise analyse in terms of capturing clear and problematic trends, and opportunities/priorities for learning.

***Benchmarking data*:** The benchmarking data is based on 969 complaints from 44 acute NHS hospital Trusts in England. The study cohort had on average 108 (range 63 to 235) thousand admissions per year and received on average 624 (range 73-2451) complaints annually. The sample included 11 teaching hospitals.

Coding: Trained coders used HCAT to codify 100 complaints from 5 pilot Trusts. Complaints were masked (to the coders) in terms of the Trust they referred to. Data were then qualitatively analysed in order to identify common trends across complaints within a Trust. Reliability has been found to be substantial for the problem categories (0.69-0.91), largely moderate for stages of care (0.38-0.66), substantial for staff group (0.62-0.64), and substantial for harm (0.68).References:

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