litigation, etcetera, but, primarily, it focuses on clinical indicators, both Health and Social Care indicators.

56 Q. This is the Clinical and Social Care indicators that comes to this committee?

A. That's a fundamental report that it looks at SAIs, it looks at incidents, it looks at clinical indicators, the outcome indicators, etcetera. That is really the channel by which Clinical and Social Care Governance is visualised at a Board level. I'm more than happy to go into, I think there are challenges in that process, but that's the vehicle by which that report presents to the --

57 Q. As I work through this, and I'm conscious I'm going to ask you questions about -- if I can call it your reform agenda, your change agenda. I want to ask you questions in that context in a moment or two. But another aspect of the Governance committee that I wish to address just now is: is the use of Clinical Governance metrics? Is the use of metrics something that you were familiar with in your role?

A. Absolutely, yes. The idea that Clinical and Social Care Governance and performance is both data driven, which clearly is metric and, therefore, intelligence, as well as looking at processing systems. So absolutely. That's fundamental to that particular report. It has been reviewed on numerous occasions to try to home in on those metrics. But, absolutely, at the heart of that report is a range of statistical

process control charts. It looks at the indicators and how we are safe or how we can become more safe.

58 Q. Was that process of gathering data and then using it intelligently, was that in good health when you came?

A. Given the fact it's an area that I think I engaged quite early on with the both Medical Director and Chair of the Committee, there was improvements to be made in that area. I think the challenge in the Health and Social Care system, and in this case the Health and Social Care Trust, is that the range of indicators could run to thousands. It really could. The challenge was to try to narrow it down into what are the key safety, quality and social care governance indicators. It was a constant challenge to try to get the right indicators. But, fundamentally, it is an area that I was involved in heavily to see how we could improve the measurement that we brought to those committees.

59 Q. You also refer in your statement to the importance of the patient/client experience committee. Its purpose was to provide the Board with assurance that the Trust's services, systems and processes provided effective measures of patient, client and care experience.

A. Yes.

60 Q. That was an opportunity, through that committee, to take a deeper dive into certain areas of clinical practice and patient experience.

A. Yes. It was a deeper dive often to patient experience.

Medical Director, we began to explore safety thermometers like in Mental Health. That was the idea of having indicators that would highlight where potentially things were starting to go slightly in the wrong direction, and that would allow the Directorate to manage and looking at those safety indicators. Mental health was the place that was also tried as well. Fundamentally what the scorecard was trying to do was get key indicators around, for example, the Acute Directorate around elective care, around unscheduled care, around monthly training, finance, those kinds of things, and making sure we were managing those on a very regular basis. I would stress that when COVID happened we changed a lot of our management processes and it became much more command and control, but up until that point we were regularly holding those meetings with Directorates and looking at the wider scale of performance.

45 Q. Was this use of scorecards within Directorates to --

A. It was.

46 Q. Was this something that surprised you in the sense that it wasn't there before?

A. Yeah. I mean having come from organisations where they were and had implemented them, I was a little surprised at the lack of structure to the management of the Directorates. What I was trying to do was bring some structure that brought together finance indicators, performance indicators, HR indicators, and allowed me, as Chief Executive, to know that the Directorates were

regularly, there should be a tool that completes it. When it's not being done, there should be Early Alerts or letting us know through a flow of information. I would have expected that to have come not only through the Medical Directorate but even in an Acute directorate, if audits weren't being undertaken, say in relation to infection control or tissue viability or whatever some of these things were, I would have expected that to come through the audit and say we are not achieving that. 12:27

Remember our leadership walks when we went out, and maybe we weren't there enough, but nobody raised any concerns with me that audit wasn't being completed, and certainly I wasn't aware. I knew about the M&M meetings, sometimes the attendance wasn't as good again due to pressures of work, but I wasn't aware that it was because of clinical audit not being done. It certainly didn't reach my level. I don't recall ever reading that on a medical director's report. 12:27 12:28

89 Q. Let me put it to you so that I can have your comments on where Mr. Devlin saw it when he came into post. If we go to his statement at WIT-00036, and just at the bottom of the page. He reports that in 2019 he commissioned two reviews to provide assurances around clinical governance processes. He says: 12:28

"Having worked in other Trusts, I was concerned that the assurance processes were not as robust as I had

looked at the governance within each directorate. The Chief Executive also would have met with her Directors very often for formal meetings and one-to-one meetings, and at least half of that time would have been on the individual corporate risk register in that directorate, 12:21
so there was time spent on that. There was, I mean, a different emphasis during her time put on governance, overarching we'll call it. I mean, there were structures put in place and different people changed roles. So as far as I am concerned, under her skilled 12:22
management and leadership the governance arrangements in the Southern Trust were as good as they could have been with all of the information flow that should have come.

12:22

We had a Board Assurance Manager, Sandra Judt, who was separate to me and the Board. She had a huge responsibility in relation to Board assurance, standards and guidelines, and was really independent really to the rest of the team, and would have been 12:22
very well informed and kept me informed as well. So I would have been very satisfied when Mrs. McAlinden left, I use the analogy, that the engine was well-oiled, it had been very well reviewed, she put in excellent processes around. For example, if I take, 12:23
say, nursing and medicine, the Medical Director, what was reporting in on his report all around re-validation; doctor that was failing, or GMC; I mean, health care acquired illnesses, to serious adverse

clinical issues or Mr O'Brien on the Risk Register or being brought by the Chair of Governance to myself.

9. Please explain your specific role as Chair in assuring yourself and the Board that the clinical governance systems in place are adequate.
Governance was always high on the Board Agenda. The Board's role and functions were clearly defined in the Governance Board Assurance Statement. At each Board meeting the agenda was alternated to have Performance Strategy and Governance given as priority.

As Chair I regularly assessed the systems through internal audit, external audit, Board Assurance Framework, Performance reports, Board Committee minutes, Serious Adverse Incidents, Medical Director and Director of Nursing reports to the Board, Patient safety and quality of care reports to the Board, Corporate Risk Register, and the Management Statement signed by the Accounting Officer – the CX.

Each CX that I worked with undertook a Clinical and Social Care Governance Review as well as the high-level overarching Governance reviews generally.

The Governance Sub Committee (I was not a member of this) of the Board was Chaired by an NED. The minutes of these Governance meetings came to Trust Board for approval. Prior to coming to the Trust Board following each of the Governance meeting the Chair of this Committee plus the CX and the Board Assurance Manager would meet with me formally in a planned diary meeting to give feedback on the agenda and the findings. A written report was always provided by the Chair in advance. This helped complete the circle of Governance.

The Leadership walks undertaken by the NEDs quarterly and me monthly provided further assurance. These Leadership reports all came to the Governance Committee as a means of reporting. Each Directorate has their own Governance Lead which fed into the structures of each Directorate. NEDS had to visit the Children's Home quarterly -

	On the basis of this, I approached the Chief Executive and asked for support in commissioning a review of CSCG across the Trust. This was undertaken through the Leadership Centre by Mrs June Champion who is a highly regarded local expert in this area. She produced the Champion Report in September 2019.
Did you have concerns about the governance arrangements and did you raise those concerns with anyone?	Yes, I had concerns about the paucity of the functions usually associated with providing a robust system of governance. I brought this to the attention of the Chief Executive, Mr Shane Devlin, who supported the commissioning of Mrs June Champion to produce the Champion Report in September 2019. In addition to this, to strengthen governance assurance in the operational directorates I introduced and led the weekly Trustwide Governance Group which includes Clinical Executive Directors and Divisional Medical Directors, which reports weekly to SMT and monthly to Trust Non- executive Directors ATTACHMENTS: CHAMPION REPORT, RESPONSE, UPDATED ACTION PLAN. Documents located at S21 No 29 of 2022, *53. CHAMPION GOVERNANCE REVIEW 2019, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS* I also had concerns about Professional Governance in the ST and this was strengthened to address these concerns.
If yes, what were those concerns and with whom did you raise them and what, if	The concerns were that the Clinical and Social Governance systems, specifically management of complaints ,SAI, standards and guidelines, clinical audit and Datix, mortality reporting and the quality assurance of these systems and triangulation of these systems were not well enough developed to provide enough governance assurance. This was raised with Mr Devlin, SMT and Trust Board and plans and funding strategies were agreed through a programme of improvement. The first aspect of this was to develop plans for improving Standards and Guidelines, Datix and SAI in year one and mortality reporting was brought up to date. Through the relevant strategies these have been progressed following significant investment.

7. What, in your experience, was the culture within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?

7.1 The Acute Directorate is very busy with significant resources required for day-to-day operational management of the service. There had been a focus on performance and finance in recent years. However, good performance increases efficiency and flow of patients both electively and non-electively to reduce waiting times and risk. There was a verbal commitment to governance but operational challenges and available funding limited time to proactively manage and respond to governance issues. A Clinical and Social Care Governance Assurance Template completed in 2018 noted a number of weaknesses and opportunities within the Acute Clinical Governance systems.

7.2 It is my opinion that the resource required to operationally and clinically manage the daily operations of the acute directorate left limited time to proactively address clinical governance processes and risks. Systems of oversight and monitoring were not well developed, some actions were taken forward by operational teams but this was not always shared with the governance team, or if not able to be progressed this was not always shared. Some work streams were supported by both the operational and governance teams.

7.3 I believe this is also demonstrated by the move of the 8A nurse from governance to lead nurse post and the redeployment of the patient support nurses to support the SAI process rather than recruiting additional staff.

7.4 There was also a lack of commitment and/or funding to providing support clinical teams, and to the audit committee to facilitate robust audit programmes with Acute Audit Committee oversight.

I then created what was in essence my manifesto as Chair of the Board of the Southern Trust about how our Board would work and our committees would work. I streamlined some of the processes around that, but primarily I was being very clear that I would be working in partnership with the Chief Executive, this is not a Chair and Chief Executive. We are both seeking the same aims here in the delivery of safe high quality care. My expectation would be that as a Board that everybody plays their part at those meetings. I touched on it yesterday when I talked about the role of Executive Directors and exactly what I expect from them and contributing to those conversations. So I have spent the last three years building up the environment for the Board. That has filtered through to the committees as well in all fairness where I am seeing Directors freely come and share their concerns that might not necessarily be on the agenda and Directors freely challenging and engage in the conversations and the discussions that we are having. I can see very clearly the topics that we are covering. Whilst they are very difficult, everybody is approaching them with the same vigour and the need to be open and transparent in what we do. 10:32 10:32 10:32 10:33 10:33

The final thing I will say on that too is that one of the important things is an organisation that is public sector, particularly Health and Social Care, is how members of the public and our staff can engage with the

Trust Board and that the Trust Board is not seen as some group of people who meet in a room with closed doors. So I very, very clearly have opened that up. People are welcome to join our meetings in person. A previous chair had opened it up as well in terms of 10:33
people being able to attend, but I have made a very concerted effort. I believe if people take the time to be with us at our Trust Board meetings and they have questions about the services we are delivering, then they should be able to ask those questions at our 10:34
meeting. I have been doing that since I have taken up. They get those questions answered at those meetings and where they don't it is followed up directly afterwards through me by the Directors.

10:34

So my efforts have been to demystify what the Board is, to take away any view or consideration that this is a secret place, it is only a certain group of people can be there, to actually open it up, that what we do there is as important, it is as important what happens in our 10:34
hospital and how that comes to us on the Trust Board and how our staff can come to our Trust Board, which they do do on a regular basis, and be part of the conversations. So that's what I have been doing for the last three years or so. 10:35

32 Q. Well just on that point, when you speak about opening up the communication lines and engaging more broadly, in relation to the other statutory bodies that have certain legislative responsibilities, RQIA, SPPG, the

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 29th March 2018
Title:	Governance Committee
Lead Director:	Chair, Governance Committee
Corporate Objective:	All
Purpose:	Approval

Summary of Key Issues for Trust Board

High level context:

i) The Minutes, for approval, contain an overview of the key discussion points and decisions from the Governance Committee meeting on 7th December 2017

ii) The Committee met on 8th February 2018.

The following key issues/risks were discussed:-

- OPPC and Acute will bring options paper back to SMT regarding Stroke services. Most likely outcome all inpatient stroke services will move from Daisy Hill to Craigavon – resulting in better service to patients. An update will be provided to the next governance committee.

- Committee received a presentation from Claire Graham, Head of Information Governance. Noted impact on Trust with removal of fees will result in a cost to SHSCT of £140k plus staff time to be assumed within current resources.

- Further work and assurances required following revised auditing for NEWS.

- Outworking's from the Hyponatraemia Inquiry will flow through to the Governance Committee and the corporate risk register.

- Updates were received on claims management, health and safety, Freedom of Information requests, Environmental Information and Subject Access requests and The Patient Client Experience Committee.

– **Feedback from meeting held on 15th February 2018**

Mrs McCartan presented the report on the subsequent meeting held on 15th February 2018 Members welcomed the detailed report provided by Mrs McCartan.

iii) **Governance Committee**

– **Minutes of meeting held on 7th December 2017 (ST827/18)**

Ms Mullan presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the meeting held on 7th December2017 (ST827/18)

– **Committee Schedule of Reporting 2018 (ST828/18)**

Ms Mullan presented the Committee Schedule of Reporting 2018 for approval.

The Board approved the Committee Schedule of Reporting 2018 (ST828/18)

– **Committee Terms of Reference (ST829/18)**

Ms Mullan presented the revised Terms of Reference for approval.

The Board approved the Committee Terms of Reference (ST829/18)

– **Feedback from meeting held on 8th February 2018**

Ms Mullan highlighted the key issues.

iv) **Patient and Client Experience Committee**

– **Minutes of meeting held on 12th December 2017 (ST830/18)**

Mrs Leeson presented the Minutes for approval.

The Board approved the Minutes of the meeting held on 12th December 2017 (ST830/18)

43.1 I think the clinical and social care governance arrangements were not fit for purpose in that more connection was required with the corporate governance arrangements. As referenced in 41.2, the only information that was escalated and shared with Trust Board about clinical concerns in Urology was from two briefing papers Dr Rankin provided on IV fluids and Antibiotics and Cystectomies in 2010. In my view, the relevance and depth of information that was escalated and shared with Trust Board members, did not provide them with robust assurance that concerns had been addressed nor enable them to make any informed decisions. I did not have any concerns specifically and therefore, would not have raised them.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

44.1 I have nothing further to add.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Strictly Private and Confidential

Clinical Issues in Urology Service
Briefing Note for Trust Board Confidential

Background on IV Fluids and Antibiotics

The clinical practice of managing recurrent urinary tract infections (UTIs) by intravenous (IV) fluids and antibiotics has become part of local urological practice over many years. This is not evidence based and has no acceptance in the wider community of UK urology surgeons.

When repeated to treat recurrent infections it can be difficult to get venous access, which has resulted in occasions where a central venous line has been inserted to administer fluids and antibiotics. This procedure carries risks in that the line is left inserted semi-permanently. Equally the patient no longer has any peripheral venous access.

The cohort of patients who have received this method of treatment has been reduced considerably to approximately 10 since January 2010.

Current Action

The Trust received a letter from the Commissioner seeking an assurance that this treatment had ceased and that no patient had central venous access. The Director of Acute Services and Associate Medical Director of Surgery and Elective Care have met the two surgeons individually to require the immediate case review of the cohort of patients. The review will be chaired by the Clinical Director of Surgery and Elective Care and will also involve Dr Damani, Consultant Microbiologist, to advise on optimum antimicrobial therapy. All future patients for who the surgeons seek to adopt IV therapy will also be reviewed in this manner. Both surgeons agreed to participate in this process which is now underway.

Background on Cystectomies

The Commissioner has also drawn to the Trust's attention a slightly increased rat of cystectomy for benign pathology in CAH when compared across the NI region. Cystectomy is the surgical excision of bladder. The numbers of patients identified are of the order to 2-4 per year.

Clinical Issues in Urology Service
Briefing Note for Trust Board Confidential

Review of patients on IV Fluids and Antibiotics

The clinical review and development of a management plan for patients which excludes routine IV fluids and antibiotics has been led by Ms Sloan, Clinical Director, Surgery and Elective Care. The review has been completed for 13 patients.

It has been decided by the clinical review team to undertake a review of the whole original cohort of patients and it will take several more weeks to complete this.

No patient in the cohort now has a central venous line.

Review of Cystectomies

The clinical review of the records of the small cohort of patients who have had surgical removal of the bladder is underway by Mr Mackle, AMD, Surgery and Elective Care. This will be completed in the next few weeks.

Regional Urology Review

The transfer pathway of patients with urological cancer requiring radical pelvic surgery or radiotherapy has been agreed. All patients are now being transferred to the Regional Urology Centre in the Belfast Trust.

Dr Gillian Rankin
Director of Acute Services (Interim)
November 2010

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

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

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

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

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

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

were emailing, is that right?

A. Well maybe if I can give some context to this. I didn't pick these two areas out of the ether. Both these areas, stroke and cardiology, were brought to me by Melanie McClements, who was the Acute Director. So it was, you know, a discussion that went on in the Committee, and that was the proper way to do it. So certainly when the issues were escalated, they were escalated to a very open and receptive Chair and Chief Executive. The Chief Executive would have had a lot more knowledge of this. So I felt that these issues were going to be very well received and that they would act on them. So I think that was the change in culture there for me in terms of escalating issues. But since that we have got, I think last September the Chair drew up, the present Chair drew up an escalation template for Committee Chairs. But prior to this, Committee Chairs did a report, anything that you were concerned about you could put in that report and send it up to the Chair and Chief Executive. 14:37 14:37 14:38 14:38

181 Q. Yes. But there is now a template to specifically allow for that. You could have done it anyway informally by email as you have illustrated, but there is now a Committee Chair template which we can see at WIT-105933, and that was appended to your most recent statement. So, just help us to better understand that. If you as a Committee Chair realise or apprehend that something needs urgent consideration by the Board, you put the details onto this and it's flagged for urgent 14:39

Southern Health and Social Care Trust

Quality Care - for you, with you

(Name of Committee)

Committee Chair Report for Board Meeting on (date)

The X Committee ('the Committee') met on (date). The following is a summary of the areas considered at the meeting to update the Board. The formal record of the meeting remains the approved minutes.

1. Summary of areas considered

(Agenda items with a note where applicable)

2. Issues for escalation to Trust Board

3. Action(s) requested/required of Trust Board

- Note the areas considered and issues for escalation
- Note previous minutes
- Approval of Terms of Reference and Annual Workplan

(Name)
Non-Executive Director - Chair
On behalf of the X Committee
(Date)

interesting. Was there really a half-day type idea where clinicians are freed up? We're very familiar in England. Here, was there a big pushback for loss of activity from either the Board or --

A. Not really. The pushback was getting everyone's diaries to coincide. I think there was a rolling audit day, I think, in surgery already. We just thought we'd use that. So there was some huffing and puffing in certain areas but everyone came along to it eventually. 15:21

146 Q. So it wasn't a big problem? 15:21

A. We got over it.

147 Q. The standards and guidelines are interesting. There are so many, aren't there, and I think every hospital struggles with that. But if something important comes along, for example prostate state cancer management for urologists, was there a mechanism that the AMDs or someone you appointed would chase up, do a sort of gap analysis or some other mechanism to see how a department was doing compared to a standard? 15:21

A. When we got standards in, we would appoint a change lead, but that was very much a volunteer and we needed someone with that particular expertise who would be the champion for the change and lead it through. So there was a process to implement standards and guidelines. I don't think we were sophisticated enough to follow up the adherence, that I can remember. I know that process of tracking standards and guidelines was new in my time. I can't claim total credit for it. There was Margaret Marshall and Anne Brennan, they were a lot of 15:21 15:22

A. Well we had just come out of Covid. Obviously a lot of beds were dedicated to Covid and recovering from that. But certainly, in terms of cardiology, my concern was that we maybe hadn't made as much progress about recovery and one of the main themes of Performance 14:31
Committee for me was a recovery plan. So we needed to look at how we were going to address those sort of concerns. I think this Consultant had been looking at national audit as well, which is always a good indicator of how we are doing, and it seemed to me that 14:32
we could improve our outcomes if we had protected bed space. Now, that's a very, very difficult thing to do, particularly when you have got such busy emergency departments. But certainly Dr. McNeany came and made his case. And I think -- was there an issue about a 14:32
scanner there as well?

178 Q. I think so. Just briefly, I just want to show, I suppose, how this was working in practice. You apprehended a real issue here but rather than just record it you put it onto the agenda of the top table 14:32
and we can see that if we go to WIT-100059. This is you writing as Chair of the Performance Committee a day or two after the meeting we have just looked at. You're telling Eileen Mullan, in her capacity as Chair of the Board and Mrs. O'Kane, who I think by this stage is 14:33
Interim Chief Executive?

A. Yes, she is.

179 Q. It's late 2022. So, you're enclosing, it's on the next page - and we needn't bring you to it - but a synopsis

Performance Committee 1st December 2022

Item 13. External Assurance - Cardiology Services

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

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

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

that he intends to bring a proposal to SMT during 2022/23 to scope the existing community and voluntary contracts against the corporate objectives and he envisaged that this may provide clarity in respect of whether any of the existing contracts should be amended/ended and if any new contracts should be commenced.

Ms Donaghy noted that EU funding is available until 2022 in relation to the mPower project and asked if funding is available beyond that. Mr Rocks advised that a number of options and discussions would be taken forward; however in the interim the learning from the mPower project will be reviewed on how best to implement it across the service.

Mr Beattie and Mr Rocks *left the meeting at this point*

Mr Wilkinson left the meeting at this point

11. SENTINEL STROKE NATIONAL AUDIT PROGRAMME

The Chair welcomed Dr Michael McCormick, Consultant Stroke Physician, Mrs Anne McVey, Assistant Director of Acute Services Medicine and Mr James Gilpin Stroke Service Improvement Lead to the meeting. Mrs McClements introduced this item and explained that the service has 19 dedicated acute stroke beds on the CAH site, DHH has a 30 bedded unit encompassing acute stroke and stroke rehabilitation patients alongside older peoples beds. She reminded members that following a local consultation on 2014 the outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised. In 2019, a subsequent regional public consultation was undertaken with CAH identified as a hyper-acute site. The outcome of the report was delayed and is as yet not concluded.

Dr McCormick presented data on the Sentinel Stroke National Audit Programme (SSNAP). He explained that the audit consists of two elements: clinical and organisational audit and explained the difference in both. Dr McCormick presented clinical audit comparable peer information on the status of stroke units across the region. He reported that the SSNAP quarterly audit performance in CAH has

Stinson, Emma M

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

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

Comac, Jennifer

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

Pauline

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

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

Eileen

Eileen Mullan
Southern Trust Board Chair

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

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

The Performance Report information was shared with the Board, and we understood the waiting lists and believe this was reported to the HSCB. If good monitoring and support was in place and good systems of work with oversight by the Head of Service and seniors, then they should have identified Urology clinical problems much earlier and sorted these with the Urology team/DoH senior officials. Action plans as referred to in 2016/17 should have been monitored for improvement through to completion.

I am sure that there are lessons to be learned in relation to how this has been managed for the SHSCT. I hope that the inquiry findings, when they are implemented, will prevent a similar reoccurrence in any of the healthcare Trusts.

68. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

I was a highly professional diligent Chair of SHSCT. I led a visible Board and believed deeply in transparency, excellent communication, and a culture of openness. I find it deeply troubling that some would attempt to place blame at my door for what has happened.
I have been open and honest about my relationship with Mr O'Brien but I would never try to use my position to influence others.

I feel more strongly about my professional reputation, my responsibilities as Chair of the Trust but most importantly about patient safety.
I really hope that there can be lessons learned and that measures can be taken to ensure that patient safety in a service is not compromised.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will

Early Alerts that came into my office and they would know every one of them that were forwarded on because, actually, I never forwarded them; it was always Jennifer that did them. I was never keen on forwarding emails directly myself; it was always done in a process through my office. But definitely, I can't think of one where it depended on the personal judgment of the Chair. I would totally refute that, I am sorry, Mr. Wolfe.

57 Q. And the Early Alert concerning Mr. O'Brien didn't fall into that category, are you saying? 10:46

A. I believe I have covered that and I am sorry if I'm repeating it again. I don't even remember getting it, I mean, and I'm happy to repeat it again; I'm asking, then, why did Jennifer or Sandra not see that as well, or with the Chief Executive, I mean, why was that not sent? But I don't want to be repetitive, but I'm sorry, I don't like my personal comments being made there, that I kept items to myself. I had a very open style of leadership, I am a very visionary, very visible, and I believed, and still believe to this day, if you're not at work tomorrow, those in your office should know what you have been doing. So Jennifer and Sandra knew exactly what I did and where I was, what came in and what went out, who I met, and all of that is clear in the diary, and I would be shocked if Jennifer Comac believed - and I am sorry, I don't see or meet these people - would say that it was an ad hoc arrangement and it depended on the judgment of the 10:45 10:46 10:46 10:47

that's just a fact, that we have to consider how they went wrong, why they went wrong, and today, with you, I just want to explore a few things concerning the role of the Board, now that we have got the opportunity to talk to you. 15:52

So one of the things you have said is that you are open, hard-working and visionary. What was your vision for the Trust?

A. Well, we had a vision, we had a strategic document of revision. What was my personal vision? 15:53

239 Q. Yes, what was your vision? How would you describe it?

A. My vision for the Trust was that, under my term, that I would be remembered for making change, making an impact, being remembered as a person who believed in the importance of high-quality care. 15:53

240 Q. Mm-hmm.

A. And I also worked tirelessly with staff at all levels, to listen to them and to see was there anything we could do, I mean, to get additional monies to help. So I just wanted the very best, and I'm pleased to say, under my tenure, whilst waiting lists may have been long, we had some amazing quality outcomes that were recognised even in Europe. We also -- 15:53

241 Q. And if you had to summarise your vision then - that was your personal mission, almost - what was the overall vision for the Trust, in one sentence? How would you describe it to staff if you were going out to say 'this is our vision'? I know there's lots of documents, I've 15:53

members had a broad breadth of knowledge and skills. Our self-assessment brought this reassurance.

5. What, if any, training did you receive to assist you in carrying out your role as Chair of the Board?

I attended numerous training sessions during my tenure and as an experienced NED across a variety of sectors both in the Private, Public and Voluntary Sectors I gained a broad breadth of skills, knowledge and experience. I also had held Senior Executive positions spanning 25 years plus. I do not have specific details of the training sessions I attended.

I remember receiving training from the Institute of Lifelong Learning at Queen's University Belfast on what a good Board looks like, on Governance, Risk, Quality Assurance, Serious Adverse Incidents and associated learning. I completed a MSC in Executive Leadership which afforded me visits to Harvard and Lausanne Business Schools this involved Governance, Human resources, Business management and a wide range of high-quality opportunities.

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

Yes, I do. We were an effective Board - used as a role model – and the members had a broad range of expertise and experience. As detailed above, we completed yearly individual assessments on our own skills and weaknesses. Training needs were identified, and training was provided. We were a forward-thinking Board and had many innovative initiatives in place.

I introduced Leadership Walks to improve the Governance arrangements. We introduced at the start of each Board meeting "Good News or Innovative stories" this detail was shared by frontline staff. We invited four or five staff from each Directorate to the Board room for their own learning and to see how the Board operated. These

A. Yes.

45 Q. What does that involve just for the purposes of learning?

A. Okay. It's an annual self assessment tool devised by the Department of Health for health and social care trusts and, I suspect, all their Arms Length Bodies within health and social care to complete. What happened was the Non-Executive Directors would meet with the Chair and discuss and complete. The executive and Operational Directors would meet with the Chief Executive and do that. Then the two pieces would come together and then that is submitted to the Department. Part of that process is about identifying areas of concern and risk, so not having a stable management team, having gaps, and Non-Execs would be part of that, and also identifying a case for learning and where there has been growth and development. 10:55 10:55 10:55

I suppose, there is two points I would like to make on it. Firstly, it's very much a tick-box exercise, not something - and I have not been an advocate of it since I first came across it - but it's a mandatory tool that must be completed and submitted to the Department. What I have attempted to do in my current role as Chair is have that as a unified conversation and a unified outcome that goes to the Department, so we work on it together as a Trust Board, which is what we did in August 2021, which was the first time we were able to physically come together post Covid. 10:55 10:56

additional different information to support its work. Each of the three Medical Directors, 2016-2019, had their own way of reporting. Dr. Maria O'Kane brought significant changes to reporting and practice with the outworkings of the Champion review. This included standards and guidelines, SAI process and complaints."

You have just mentioned the Champion review and other changes that have come about. Just to make sure you have covered what other improvements there might have been in relation to reporting aspects of clinical and social care governance, is there anything else new or that has evolved since the Inquiry has started that you wish to bring to the Inquiry's attention? 10:05

A. The next phase of the changes - yes, there has been - and the next phase of the changes are around the clinical audit, the governance leads and bringing them in in a unifying manner. And, forgive me, it will come back to me, there is a third bit. So we have taken the Champion review, these three bits have been worked through and continuing. There is a continual journey with this in development. Then the next section is around the clinical audit and certainly bringing together unified governance leads rather than working in silos and that reporting then through to the operational groups that I spoke about earlier. 10:06

7 Q. If we go to WIT-100546, at paragraph 47.1. You were asked a question: Are you now aware of governance concerns arising out of the provision of Urology

Southern Health and Social Care Trust
Quality Care - for you, with you

COMMITTEE	**SHSCT Morbidity & Mortality Strategic Oversight Group** **Terms of Reference**
CONSTITUTION	The Medical Director hereby resolves to establish a sub-group to the Trust's Senior Management Team, to be known as the Mortality & Morbidity (M&M) Strategic Oversight Group.
PURPOSE	The purpose of the M&M Strategic Oversight Group is to: • Provide high level oversight and assurance that effective systems and processes are in place for review of mortality and morbidity. • Ensure the capturing, sharing and implementation of learning and good practice arising from M&M meetings • Consider mortality reports i.e. SHMI / RAM I to identify early alerts or areas where more detailed review is required.
MEMBERSHIP	**Chair:** • Medical Director • Executive Director of Nursing / AHP (Co-Chair) **Membership:** • Non-Executive Director • Associate Medical Directors x 2 • Assistant Directors, Operational Directorates x 2 • Clinical Directors x 2 • M&M Chairs x 2 • Assistant Director, Medical Director's team • Assistant Director, Clinical & Social Care Governance • Assistant Director, Nursing Governance • Assistant Director, AHP Governance • Head of Performance • Head of Information and Data Quality • SAS Lead • Chief Registrar / Trainee doctor representative • ADEPT Fellow, (as applicable) • Head of Midwifery / Lead Midwife • Clinical and Social Care Governance Co-Ordinator, MHLD • Senior M&M Facilitator • Head of Patient Safety Data & Improvement • CYP Medical Representative • Social Services Representative Members should aim to attend all meetings. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **In attendance:** Any officer of the Trust or of an external agency such as the HSCB or PHA may, where appropriate, be invited to attend. **Member appointments:** The membership of the M&M Strategic Oversight Group shall be determined by the Medical Director, taking into account the skills and expertise necessary to deliver the Group's remit.
DUTIES	The **main responsibilities** of the group are to: • Provide assurance to Trust Board that all hospital deaths are proactively

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 9th November 2021
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview:

Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Key Issues / Risks for SMT Consideration:

- 95 ongoing SAIs
- Executive Directors meeting in December to provide oversight of SAIs within the Trust to identify learning for improvement and themes.
- Point 1 – Acute – 39 SAIs
- A meeting is scheduled to finalise the paper in relation to the COVID SJR process. The Trust is also meeting with the NHSCT to compare both processes to ensure they are consistent.
- Point 9 – MHD – 37 SAIs (8 are nearly ready for submission to HSCB)
- Point 10 – MHD – 2 new SAI notifications regarding suicides within the Community
- Point 13 – MHD – 5 Early Alerts/Updates relating to Covid Outbreak in Willows Ward, Seclusion arrangements for one service user and staffing levels within Bluestone.
- Point 15 – MHD – Directors Oversight Group for Granville and Dorsy - The Dorsy oversight group has developed a dataset which will be monitored on a weekly basis. The dataset was finalised following a comparison of the assurance dataset now used in Muckamore Abbey Hospital.
- Point 18 – CYPS – New SAI Notification - Delay in treatment around blood transfusion, care during admission and Ambulance transfer.
- Point 19 – CYPS – 2 SAI Reports submitted – 1 regarding a Child Death and another relating to sexual assault within the Community. Governance staff are establishing if the statutory roles for offering support to LAC is audited.
- Point 31 – Learning Identified from Claims, to be shared with M&M for dissemination. Ongoing discussions regarding the dissemination of learning for all multidisciplinary staff.
- Point 32 – 3 Preliminary inquest hearings listed for November.
- Point 35 – Safeguarding – Acute Social Work at full capacity and unable to take on new cases. Ongoing discussions with the Head of Adult Safeguarding, Acute Social Work and AD in Acute Services.
- Point 37 - 2 Data breaches reported to the ICO, meeting organised to discuss the learning from one of these incidents.
- Point 39 – Slight reduction in the number of outstanding Freedom of Information Requests
- Point 40 – 2nd Line assurance submitted some Infection Risk when using FFP3 Respirators with Valves or Powered Air Purifying Respirators (PAPRs) during Surgical and Invasive Procedures.
- Point 41 – 3rd Line assurance requested for Risk of serious harm or death from choking on foods
- Point 49 – Response attached to the PHA regarding Falls and Pressure Ulcers.

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board Meeting 25th January 2024	
Title of paper	People and Culture Steering Group	
Accountable Director	Name	Vivienne Toal
	Position	Director of Human Resources and Organisational Development
Report Author	Name	Maxine Williamson
	Email	[redacted]
This paper sits within the Trust Board role of:		Culture
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

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

Health and Social Care

The Regulation and Quality Improvement Authority

A Framework for Safety Culture within Health and Social Care in Northern Ireland

www.rqia.org.uk/BeingHuman
info@rqia.org.uk

Acknowledgements

RQIA would like to thank all of those involved in this work, including co-production partners, people with Lived Experience, external experts, and key stakeholder organisations, for contributing their time and providing knowledge and expertise to support the development of ***Being Human: A Framework for Safety Culture within Health and Social Care in Northern Ireland***.

This includes representatives from:

- Department of Health
- General Medical Council
- Health and Social Care Trusts
- Northern Ireland Medical and Dental Training Agency
- Northern Ireland Practice and Education Council for Nursing and Midwifery
- Northern Ireland Public Services Ombudsman Office
- Northern Ireland Social Care Council
- Nursing and Midwifery Council
- Patient Client Council
- People with Lived Experience
- Public Health Agency
- Regulation and Quality Improvement Authority (including Health and Social Care Quality Improvement Northern Ireland)
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Psychiatrists
- Royal College of Surgeons
- Trade Unions
- Ulster University
- Voluntary Sector Organisations

We very much appreciate their dedication and commitment to improving safety culture within Health and Social Care to ensure that it one which is ‘Safe and Compassionate’, ‘Just and Open’, and ‘Continually Learning and Improving’.

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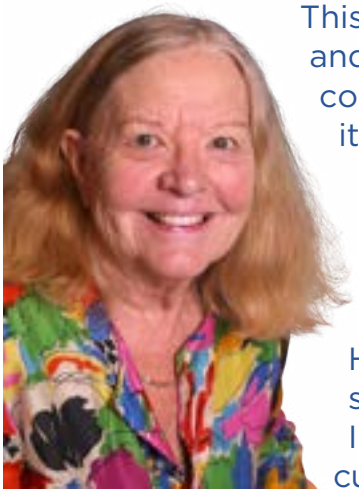
Foreword



This “Being Human Framework”, based on our existing Health and Social Care Standards, has been developed through co-production by the Health and Social Care system and its users.

It comes at a critical juncture for the Health and Social Care system in Northern Ireland. It springs from RQIA’s Legacy Commitments, following from the Review of the Records of Deceased Patients of Michael Watt, the experience of the Hyponatremia Inquiry and other inquiries, to ensure that sustainable action results from past failings within Northern Ireland’s HSC, and the NHS more widely. These all identified cultural issues as key to poor behaviours and poor patient safety.

The Framework is both a response and a renewal: a deliberate effort to reframe patient safety as a deeply human endeavour, not as some kind of “forced function” to comply with policy or procedures. The Framework recognises that no amount of procedural, policy or process change can or will change our culture and our behaviour. Changing the culture of an organisation, and the system as a whole, requires informed and intelligent leadership; a deliberate choice to change; and to sustain that change in mindset and in behaviours.

This Framework aims to give the leaders of organisations, at all levels and in all roles, a shared vision of ‘what good looks like’ in terms of patient and of staff safety, and a shared means of assessing and evaluating their individual organisational safety culture. Between the vision and the evaluation comes the shared preparedness and the collaborative actions through improvement action plans, creating and sustaining the cultural and behavioural change.

The Framework provides the basis for a shared understanding and common approach to other policies, whether SAI’s, Being Open, MHPS. It does not require legislation; it requires determination, and shared purpose.

Historically, attempts to improve safety have led to revised regulatory and process-driven mechanisms. Yet, evidence and experience consistently demonstrate that mechanistic systems alone do not create safety — humans do. It is the interaction between human beings and systems, and the culture that surrounds them, that ultimately determines whether our care environments are safe. Safe for patients; safe for staff; and so creating safe space for the HSC as a whole system to learn and to improve.

People need to feel psychologically safe so they are able to ask questions, make suggestions and raise concerns. Concerns raised by patients, families or HSC staff must be heard, understood, and acted upon. To do anything else is a breach of trust and counter to the ‘Duty of Quality’ to patients and ‘Duty of Care’ to staff.

Northern Ireland’s HSC system is complex and varied. There are many examples of good practice, as well as many challenges. Where we have examples of safe and compassionate cultures within our system, these must be recognised, celebrated, promoted, scaled up and spread.

Foreword

Here, the recent incorporation of the Health and Social Care Quality Improvement unit into RQIA is a very welcome recognition, rationalisation and reinforcement of capacity. This change gives statutory backing to the QI movement and reinforces its alignment with HSC's strategic aims. It will strengthen support for the HSC trusts through their QI Alliance, a resource that embeds collaboration and consensus. It will mirror and support the undertakings of the 'Committee in Common' for shared purpose and delivery.

The *Being Human Framework* sets out what good practice looks like. It harnesses appreciative inquiry to foster a culture that is person-centred and relationship-focused. It draws upon the core values of our Health and Social Care system — compassion, openness, honesty, collaboration, and excellence. It places recognising and meeting human needs and rights at the centre of care. It recognises that people flourish when their needs are met, when they are treated with respect, and when authentic human connection is fostered through compassionate leadership.

The Framework also acknowledges the inevitability of human error. It advocates for a culture where honesty is encouraged, and where learning and improvement are embraced. A culture where mistakes are not hidden but reported. When harm occurs, the response offers compassion, timely apology, acknowledgement, and answers. Accountability is not punitive — it is a pathway to healing for individuals and positive change for the system itself.

"Being Human" is a call to collective responsibility and collective leadership. It invites all of us — clinicians, leaders, regulators, and service users — to co-create a culture that prioritises safety, wellbeing, and trust. It is not a static document, but a dynamic Framework for reflection, dialogue, and continuous improvement.

Working together we can cultivate a culture that is 'just and open'; 'learning and improving'; and, 'safe and compassionate'.

Personal Information redacted by the USI

Christine Collins, MBE
Chair, RQIA

Executive Summary

In recent decades, there have been numerous public inquiries into repeated failings within the Health and Social Care service, and NHS more widely, where lessons have been learned, yet not learned in any meaningful way. As strategies to improve governance systems and processes by themselves have not led to substantial improvements in patient safety, the role played by culture within Health and Social Care (HSC) has become increasingly evident.

Being Human: A Framework for Safety Culture within Health and Social Care sets out what a good safety culture looks like within HSC in Northern Ireland. It defines safety culture as one that is 'Safe and Compassionate', 'Just and Open', and 'Continually Learning and Improving'.

'Being Human' delineates a shift away from rigid process-driven, 'tick box' approaches to health and social care, and focuses on embedding a relational, person-centred ethos at all levels of the HSC system; understanding that our shared humanity and the relationships we have with each other, as patients, family members, colleagues and leaders, are our greatest asset to ensuring a safe, high-quality HSC system.

Underpinned by HSC Values, and aligned to best-practice standards, including DoH Quality Standards 2006, the Framework defines three overarching domains that represent the collective mindset necessary to drive a strong safety culture.

- **Domain 1: Commitment to Patient Safety and Staff Wellbeing**
- **Domain 2: Compassion, Civility and Respect**
- **Domain 3: Curiosity and Constructive Challenge**

Each of these domains encompass a number of expectations for HSC Organisations, underpinned by a series of indicators, setting out the enabling system factors, behaviours and outcomes that provide evidence of a good safety culture. Accompanied by case studies, good practice examples, along with examples of poor behaviour, it is designed to be enabling and empowering for HSC staff, patients and families.

Recognising that 'culture comes from the top', the Framework is of particular benefit to HSC Trust Boards, and newly established Patient Safety and Quality Committees, as they determine how best to improve and assure safety for staff, patients and the public. It is not a one-off and standalone piece of work, but rather the continuation of an upward journey.

In the short-to-medium term, further work is required to develop the tools, guidance and any adjuncts necessary to facilitate Framework implementation and evaluation. In the longer term, it will require whole-system adoption in order to maximise safety culture within all aspects of Health and Social Care.

Meanwhile, the Framework should be embraced and utilised to shift mindsets, influence behaviour and define the actions required to embed a 'Safe and Compassionate', Just and Open and Continually Learning and Improving Culture within HSC.

Being Human: A Framework for Safety Culture within Health and Social Care

Domains	Themes	Expectations
Commitment to Patient Safety and Staff Wellbeing	**Fostering collective accountability for Patient Safety**	There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board
		There is a 'Floor to Board' commitment to patient safety
		Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice
		Tackling Health Inequalities is a Key Safety Priority
	Looking after staff wellbeing	Staff are nurtured, supported and enabled to fulfil their potential
		Diversity is welcomed, championed and supported, understanding that it makes teams more effective
	Listening to patients, families and staff	Voices of staff, patients and families are embraced as an important barometer of safety
Compassion, Civility and Respect	**Leading with compassion**	Compassionate Leadership is fundamental to all other aspects of a safety culture
	Empowering staff, patients and families	Effective Teamwork and Psychological Safety is nurtured within teams
		Staff at all levels are kind and civil and work within 'Safe and Compassionate' teams
		Patients and families are empowered, enabled and informed
	Enhancing openness, trust and mutual respect	Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues
		All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions
		Openness and candour is promoted and supported at all levels in the organisation
Curiosity and Constructive Challenge	**Addressing fear and defensiveness**	Fear is addressed by acknowledging the impact of past trauma and by challenging unhelpful narratives and beliefs
		Early engagement is embraced as an opportunity for early resolution and system learning
	Making it safe for staff to speak up	Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system
		Speaking up is highly valued and encouraged and results in action to improve patient safety
	Being curious to learn and improve	Time and space for reflection is created at all levels in the organisation
		Learning is shared in a meaningful way that has impact

Background and Context

The core purpose of the Regulation and Quality Improvement Authority, as the system regulator for Health and Social Care (HSC) in Northern Ireland, is to secure and improve the safety and quality of health and social care services.

In November 2022, RQIA made a number of Legacy Commitments in relation to the improvement and assurance of safety culture within HSC.[i]

These commitments were made following the stark learning arising from RQIA Expert Review of Records of Deceased Patients of Michael Watt[1], which raised significant concerns about how patients[ii], families and HSC staff experience culture within the Northern Ireland Health and Social Care System. RQIA had the privilege of meeting with families who shared testimony of not being listened to, not being treated with empathy, compassion or respect, and of healthcare professionals seeming disempowered to raise concerns. These concerns echo the findings of numerous Inquiries and Reviews within HSC, and the NHS more widely, undertaken in recent decades; all of which highlights a need for a concerted effort to improve safety culture within our Health and Social Care Service.

Following significant scoping work and engagement with stakeholders across the region through a series of Roundtable Discussions[2,3], it was determined that in order to fulfil RQIA's Legacy Commitments, there was a requirement for an overarching Framework to set out clear expectations for how safety culture may be strengthened and assessed within HSC.

In December 2024, RQIA secured a mandate from system partners and representatives with Lived Experience to take this work forward by co-production.

How we developed the Framework

Co-production Model

RQIA developed a Co-Production Model to ensure a robust approach to the Framework's development and a Co-Production Charter to ensure adherence to best practice principles in co-production.

The Framework was developed by Co-Production Partners working together in three work streams:

1. Safe and Compassionate;
2. Just and Open;
3. Learning and Improvement.

[i] Legacy Commitment 7: Strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns.
Legacy Commitment 8: Require improvements if there is evidence of substandard systems, or poor culture or care.
Legacy Commitment 9: Use its position as independent regulator to support the adoption of openness and candour across all services, especially when reporting that care has gone wrong.

[ii] For the purpose of this document, it was agreed that the term 'patient' would be used throughout recognising that it is an umbrella term for an individual in receipt of Health and Social Care Services.

Background and Context

A Steering Group was established for oversight, assurance, advice and guidance around the approach to co-production, communication, engagement and involvement and publication plan in respect to the Framework.

An Expert Reference Group was established to quality assure outputs of the work streams, with feedback provided to each work stream to implement.

Engagement and Involvement

In parallel with development of the Framework, a sense-check process was undertaken to ensure alignment with other pieces of regional work currently underway to improve safety culture within HSC[iii].

Engagement and Involvement was undertaken with HSC Trust Boards, HSC staff groups, Lived Experience representatives, and Community and Voluntary Sector Organisations through a series of focus groups.

Approval

The final Framework was approved by the RQIA Authority in August 2025.

Scope of the Framework

HSC Trusts

The Framework is intended for use within HSC Trusts. Whilst its principles can be applied to other settings, such as primary care, the independent sector, and health and social care settings in other jurisdictions, the Framework has been developed with the specific intention of assuring and improving safety culture within the six Health and Social Care Trusts in Northern Ireland.

Primary Care

Primary Care is the first point of contact for people with health and social care needs. RQIA does not presently have regulatory oversight of Primary Care within Northern Ireland but recognises the vital importance of driving a safe and compassionate culture within Primary Care, particularly within the General Practice (GP) setting. Further work is required to adapt the Framework for use within Primary Care, including GP Services.

[iii] These included: DoH-Led Being Open Framework, Redesign of SAI process, Establishment of HSC Trust Board Patient Safety and Quality Committee, NI Practice and Education Council Quality Excellence Framework and Reform of Complaints Handling led by NI Public Services Ombudsman.

The Purpose of the Framework

Underpinned by the core values, principles and standards for Health and Social Care, including DoH Quality Standards 2006[4], the purpose of the Framework is:

1. To set out expectations of what a good safety culture looks like for HSC system, patients and the public.
2. To provide the foundation for assessing safety culture within HSC organisations.[iv]

The Framework, the process of developing it, and any accompanying tools and guidance, are intended to achieve an overall aim of fostering a culture within the HSC system that is safe and compassionate, just and open, and continually learning and improving.

The Framework is designed to:

- Define a culture within HSC that is safe and compassionate; just and open; continually learning and improving.
- Support HSC Trust Boards and senior leaders to foster a safe and compassionate; just and open; continually learning and improving culture within HSC services through: consistent compassionate leadership; scaling up and spreading good practice; and promptly identifying and addressing poor practice;
- Be meaningful and relevant to all those who use it, by setting out how its principles may be practically applied in real life situations
- Enable and empower HSC staff, patients and families to articulate the safe and compassionate environments they deserve to encounter, whilst empowering them to constructively challenge when standards fall short of what is required to ensure staff and patient safety
- Set out clear expectations for the HSC system, that are underpinned by core values, principles and standards for Health and Social Care, including DoH Quality Standards 2006.
- The Framework, underpinned by the DoH Quality Standards 2006, is designed to set out 'what good looks like' in relation to safety culture within HSC organisations. It will inform the development of assessment tools and guidance that can be used for self-assessment by HSC Trust Boards, and will be of value to newly established Patient Safety and Quality Committees.
- The Framework will be used by RQIA as part of its function to inform the DoH of the quality and safety of HSC services.[v]

[iv] Assessment methodology and tools to be developed as part of Phase 2.

[v] Under the 2003 Order, the Regulation and Quality Improvement Authority has statutory functions to conduct reviews, inspections and investigations of, and make reports on, arrangements by HSC Trusts for the purposes of monitoring and improving the quality of the HSC services.

Being Human: A Framework for Safety Culture within Health and Social Care

Domains	Themes	Expectations
Commitment to Patient Safety and Staff Wellbeing	**Fostering collective accountability for Patient Safety**	There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board
		There is a 'Floor to Board' commitment to patient safety
		Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice
		Tackling Health Inequalities is a Key Safety Priority
	Looking after staff wellbeing	Staff are nurtured, supported and enabled to fulfil their potential
		Diversity is welcomed, championed and supported, understanding that it makes teams more effective
	Listening to patients, families and staff	Voices of staff, patients and families are embraced as an important barometer of safety
Compassion, Civility and Respect	**Leading with compassion**	Compassionate Leadership is fundamental to all other aspects of a safety culture
	Empowering staff, patients and families	Effective Teamwork and Psychological Safety is nurtured within teams
		Staff at all levels are kind and civil and work within 'Safe and Compassionate' teams
		Patients and families are empowered, enabled and informed
	Enhancing openness, trust and mutual respect	Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues
		All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions
		Openness and candour is promoted and supported at all levels in the organisation
Curiosity and Constructive Challenge	**Addressing fear and defensiveness**	Fear is addressed by acknowledging the impact of past trauma and by challenging unhelpful narratives and beliefs
		Early engagement is embraced as an opportunity for early resolution and system learning
	Making it safe for staff to speak up	Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system
		Speaking up is highly valued and encouraged and results in action to improve patient safety
	Being curious to learn and improve	Time and space for reflection is created at all levels in the organisation
		Learning is shared in a meaningful way that has impact

Introduction to Being Human: A Framework for Safety Culture within Health and Social Care in Northern Ireland

Health and Social Care (HSC) systems, clinical pathways and treatments, and the patient populations they serve, have become increasingly complex. Delivering high-quality care in the current climate of fiscal challenges and workforce pressures, can at times feel aspirational. Health and Social Care professionals frequently report burn out, moral distress and moral injury whilst the public express decreasing confidence and mounting frustration due to chronic issues with accessibility, at multiple points in the system – primary care, Emergency Departments, outpatient waiting times, and surgical waiting lists.

Furthermore, in recent decades, there have been numerous public inquiries into repeated failings within the Health and Social Care service, where putative lessons have been learned, yet not learned in any meaningful way.[5]

As strategies to improve governance systems and processes, by themselves, have not led to substantial improvements in patient safety, the role played by culture within health and social care has become increasingly evident.

No-one understands culture better than those who live it and are impacted by it. This includes patients and families who have Lived Experience of using services, some of whom have shared harrowing testimony of healthcare-related harm, and also staff who work within services daily to deliver care. Staff acutely understand the pressures within the HSC system, and may themselves have experienced harm due to cultures that are not as fair, open or supportive as they should be.

Our engagement with these Experts by Experience has sent a resounding message that the prevailing culture must fundamentally change. That is not to say that good practice does not exist. There are lots of examples of good practice, some of which are highlighted within this Framework. Where good practice is evident, it must be recognised, celebrated and spread. A strong safety culture must become the norm - not the exception.

It is a point recognised by our partners within HSC system – Department of Health, HSC Trusts, Patient Client Council, NI Public Services Ombudsman, NI Practice and Education Council and Professional Regulators – all of whom, are involved in leading important work to improve safety culture within HSC. The values, principles, and standards underpinning our collective efforts are referenced within this Framework.

Together, we have a shared vision for a safety culture within HSC that is safe and compassionate for patients and staff, just and open, and continually learning and improving. In order to realise this vision, we must first define it by setting out what good looks like and how we can achieve it.

Defining Safety Culture for Health and Social Care in Northern Ireland

A safety culture within HSC is one that is:

1. Safe and Compassionate;
2. Just and Open; and
3. Continually Learning and Improving.

1. Safe and Compassionate

What does this look like?

There is a continuous drive to provide safe and compassionate care to patients and staff. Staff are supported, nurtured and enabled so that they can look after their patients. Patients are listened to, receive empathy, compassion and respect, and are treated as partners in making decisions about their care.

There is psychological safety within teams, where staff feel safe to ask questions and learn, safe to discuss ideas on how to improve, and safe to communicate and raise concerns so that patients and staff can be safeguarded from harm.

There is also psychological safety for patients and families, who are empowered, supported and enabled to raise concerns about care and treatment, to have their voices listened to so that the HSC system can learn and improve.

2. Just and Open

What does this look like?

A just and open culture is one where fairness, openness and learning are embedded within the Health and Social Care system; and where staff are encouraged to raise concerns, safe in the knowledge that action will be taken and that they will be supported and protected from unfair treatment.

It is characterised by a compassionate and supportive environment for staff, patients and families, who can trust that in the aftermath of health-care related harm, their needs will be considered and that their confidence will be restored through open acknowledgement of impact of their experiences and a genuine commitment to drive system learning and improvement.

There is openness and candour at all levels in the organisation, where staff are supported to engage early with patients, victims and families who have experienced healthcare-related harm, in order to promote healing, restoration of trust through human interaction, sincere apology, acknowledgement of harm and provision of open and honest information.

3. Learning and Improvement

What does this look like?

There is a 'floor to Board' commitment to learning and improvement. It is characterised by a strong learning ethos which encourages contribution from all, recognising that the voices of staff, patients and families are an important barometer of safety.

There is a commitment to learning from good practice as well as from harm and to ensure that learning is shared in a meaningful way and has measurable impact.

Staff at all levels are empowered and enabled to achieve their potential; appreciating that diversity and inclusion results in more effective teams, and greater creativity and innovation.

What ensures we achieve a good safety culture?

Culture can be defined as the collective values, attitudes and behaviours of a group of individuals, working within a system, organisation, service or team.

Values

Values are an enduring set of principles and ideals that guide how people think, feel and behave.

A person's value-base may be shaped by their intrinsic nature, lived experiences, moral beliefs instilled through their upbringing, education and training, and codes of conduct set out by their profession or organisation.

Within Health and Social Care Organisations, there is an expectation that all individuals will adhere to HSC Values.[6]

These are:

- **Working Together** – Working well with colleagues, other teams, external organisations and agencies; working in partnership with patients and families;
- **Openness and Honesty** – Being open and honest, acting with integrity and candour;
- **Compassion** – Being kind, empathetic, supportive to patients, families, and colleagues;
- **Excellence** - Committing to being the best we can be, putting the needs and safety of patients before self-interest; reflecting the vocational and altruistic reasons why many enter health and social care.

Whether individuals remain true to HSC values, by consistently behaving in ways that are aligned to them, may be influenced by the context, environment, and prevailing attitudes and beliefs in the organisations within which they work.

Attitudes and Beliefs

The attitudes, beliefs and assumptions of individuals constitute a mindset. Mindsets may be shaped by organisational narratives and the lived experiences of how leaders and colleagues are observed to behave and act, including how they treat others on a day-to-day basis and at times of stress.

These narratives and experiences are crucial in setting an 'internal compass' or benchmark for behaviour that is perceived to be:

1. 'acceptable' (i.e. I must be professional, kind and civil at all times);
2. 'safe' (i.e. It is safe for me to raise concerns about patient safety);
3. 'moral' (i.e. I must be open and truthful at all times).

Perceptions around what are acceptable, safe and moral behaviours, further perpetuate the culture[7], otherwise known as how 'we do things around here' or 'how we do things around here when no one is looking'.

How do we ensure that our internal compass points in the right direction?

In the context of Health and Social Care, there are three high-level domains, for driving a culture that is safe and compassionate, just and open, and continually learning and improving.

Each domain represents a collective mindset for achieving and sustaining improvement in safety culture:

Domain 1: Commitment to Patient Safety and Staff Wellbeing

Domain 2: Compassion, Civility and Respect

Domain 3: Curiosity and Constructive Challenge

In the sections below, each domain is explored to identify expectations for the HSC system, along with a set of indicators; these represent the actions, behaviours and outcomes that are consistent with strong safety culture.

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Cultural Domain 1: Commitment to Patient Safety and Staff Wellbeing

Domains	Themes	Expectations
Commitment to Patient Safety and Staff Wellbeing	**Fostering collective accountability for Patient Safety**	There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board.
		There is a 'Floor to Board' commitment to patient safety.
		Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice.
		Tackling Health Inequalities is a Key Safety Priority.
	Looking after staff wellbeing	Staff are nurtured, supported and enabled to fulfil their potential.
		Diversity is welcomed, championed and supported, understanding that it makes teams more effective.
	Listening to patients, families and staff	Voices of staff, patients and families are embraced as an important barometer of safety.

Expectation 1: There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board

1.1 There is a shared vision for 'Patient and Staff Safety', understood by staff working at all levels, which clearly sets out a shared responsibility and collective accountability for 'Patient and Staff Safety'.[vi]

1.2 HSC Trust Boards demonstrate a commitment to the Duty of Quality. This is evidenced in their approach to: oversight and assurance of patient safety and staff wellbeing; openness and transparency around patient safety and staff wellbeing metrics; commitment to continuous learning and improvement.

1.3 HSC Trust Boards ensure that there are safety management systems in place, to support a strong safety culture within HSC services.

1.4 HSC Trust Boards, Senior Leaders and Leaders and managers are routinely open about organisational performance, patient safety and staff wellbeing. Metrics are routinely shared for the purposes of assurance, benchmarking performance and openness and transparency with staff, patients, families and the public.

1.5 HSC Trust Boards and Senior Leaders have in place robust monitoring arrangements for Patient and Staff Safety. These take into consideration a holistic approach to assurance, integrating patient and staff feedback with other indicators of safety.

1.6 HSC Trust Board Patient Safety and Quality Committees triangulate information, including both quantitative and qualitative patient and staff feedback, in order to provide a high-level overview of patient safety and staff wellbeing.

1.7 HSC Trust Boards, via Patient Safety and Quality Committees, work effectively to identify key safety priorities and advise on strategic approaches to improvements. This includes oversight and ongoing assurance, including an understanding of when independent assurance and external expert advice and support may be required.

1.8 HSC Trust Boards and Senior Leaders demonstrate an understanding that they are accountable for promoting a just, open and learning culture within the organisation.

1.9 HSC Trust Boards have arrangements in place to monitor a culture that is consistent with safety, compassion, fairness and openness.

1.10 HSC Trust Boards and Senior Leaders role model behaviours consistent with the values of HSC.

1.11 HSC Trust Boards and Senior Leaders set clear expectations for staff in respect of values and behaviours consistent with a positive workplace culture.

1.12 Staff at all levels understand the values and standards of behaviour to which they are expected to demonstrate and for which they will be held accountable.

1.13 Leaders and Managers at all levels are provided with training, resources and support to manage and address the behaviours of direct reports, staff and teams, that are not consistent with the values of HSC.

1.14 Where individual performance is of concern, managers in the first instance adopt a supportive approach in order to seek early resolution. Managers receive training and guidance on how to support staff with performance issues.

DoH Quality Standard: 4.3 Corporate Leadership and Accountability of Organisations

[vi] A broad definition of accountability is adopted which includes: acknowledging our roles and responsibilities, taking ownership of our actions and behaviours, being open and honest, a commitment to learning from mistakes, and contributing positively to system learning and improvement.
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1.1 Collective Accountability

What is accountability?

Accountability is often interpreted as being synonymous with ‘blame and punishment’.

In the context of HSC system failings, when the media and public speak about ‘holding someone accountable’ we often envisage that this means someone will be reprimanded, lose their job, be prosecuted or publicly shamed for their actions; these often unhelpful and anxiety-provoking connotations of accountability are also shared by HSC staff, leading to a pervasive sense of fear within the HSC system.

In the presence of fear, festers a culture of defensiveness, blame and secrecy; all of which are counter to the true meaning of accountability.

The true meaning of accountability

‘Accountability is a privilege’, needing not to be ‘reframed’, but properly understood, and claimed with pride by all who work within the Health and Social Care System.

Accountability can be viewed as encompassing four broad elements:

1. **Responsibility;**
2. **Ownership;**
3. **Being Open;**
4. **Learning from mistakes.**

Individuals demonstrate their commitment to accountability in the following ways:

Element	Individuals	Why accountability is positive
Responsibility	Accountability starts with acknowledging our roles and responsibilities and accepting that we have agency over our actions and behaviours.	It is a privilege to work within the HSC system, to have a role in serving and caring for those who need Health and Social Care.
Ownership	We take ownership of our actions and behaviours, ensuring that they align with HSC values, understanding that we are answerable for how we act and behave.	With this come dedication and commitment to living the values of HSC. When we experience challenges, we can be proud that we remained true to HSC values.
Being Open	Being open is an integral part of accountability. It means being open about our actions and behaviours, and their outcomes, even if those outcomes are not what we intended. Being open is an important aspect in maintaining the trust and confidence of others.	When care has gone wrong, we can feel proud of being open, honest and forthcoming, understanding that being open provides an opportunity for healing and recovery for those who have been harmed, and for system learning and improvement. Being open serves to maintain and restore trust and confidence in the Health and Social Care System.
Learning from mistakes	Accountability requires us to acknowledge and learn from our mistakes - seeing mistakes as an opportunity for personal growth. It requires us to accept responsibility for our actions and behaviours, to reflect on what went wrong, and take steps to rectify or improve.	When we make mistakes or are involved in safety incidents, we can be proud that we are committed to learning from what has happened for professional development and to contribute to making system improvements to avoid similar happening in future. This learning will improve patient safety going forward.

Accountability for individuals is to be viewed as a positive, to be held with honour as a staff member working within HSC. When we behave in ways that are accountable, we demonstrate that we are 'living the values' of HSC.

However, if our behaviours do not align with HSC values, as individuals we should all be prepared to be answerable for our behaviour and to accept responsibility for the consequences of our actions.

Behaviour such as dishonesty, deceitfulness and causing deliberate harm to patients and colleagues (including bullying and harassment) will have significant consequences for individuals. The majority of HSC staff do not behave in such ways and therefore have nothing to fear from 'accountability'.

What good looks like: Living the HSC Values

- Senior Leaders role model the behaviours consistent with HSC Values;
- HSC Organisations set clear expectations for staff in respect of values and behaviours;
- Staff at all levels understand the values and behaviours they are expected to demonstrate;
- Managers are provided with training, resources and support to address behaviours of individuals that are not consistent with the Values of HSC.

Whilst all individuals are accountable for their behaviours and actions, it is HSC Trust Boards that are ultimately accountable for patient safety through their 'Duty of Quality'.[vii]

[vii] The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003' applied a statutory duty of quality on the HSC Trusts.

HSC Organisations can demonstrate their commitment to accountability in the following ways:

Element	HSC Organisations
Responsibility	• There is a statutory 'Duty of Quality'[viii], ultimate responsibility for Quality and Safety sits with the HSC Trust Board.
Ownership	• There is a shared vision and strategic direction, clearly understood by staff working at all levels, which sets out a shared responsibility and collective accountability for Patient and Staff Safety. • HSC Trusts ensure there are appropriate safety management systems, oversight and assurance of patient safety and staff wellbeing. • There are robust monitoring arrangements in place for Patient and Staff Safety that adopt a holistic approach to assurance, integrating patient and staff feedback (qualitative and quantitative) with a range of other meaningful safety indicators. • HSC Trust Boards, via Patient Safety and Quality Committees, identify key safety priorities and advise on strategic approaches to improvement.
Being Open	• HSC Trust Boards, Senior Leaders and Leaders and managers are routinely open about organisational performance, patient safety and staff wellbeing. Metrics are routinely shared for purposes of transparency, assurance and benchmarking in order to drive improvement. • A just, open and learning culture is fostered at all levels within HSC organisation. There are arrangements in place for monitoring the culture. • There is organisational candour. Staff are supported and feel safe to be open and honest when care goes wrong.
Learning from mistakes	• HSC Trust Boards are committed to continuous learning and improvement. • There are systems and processes in place for incident reporting and review. Incidents are examined with an understanding of system and human factors. • Learning is identified with a view to driving system improvements in patient safety. Learning is shared in a meaningful way and has measurable impact.

[viii] The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003' applied a statutory duty of quality on the HSC Trusts.

Creating a Culture of Accountability

Creating a culture of accountability can serve to enhance shared responsibility for patient safety.

Leaders play an important role in fostering a culture of accountability by:

- Being explicit about goals and intentions;
- Setting clear expectations;
- Providing autonomy and support for staff;
- Monitoring performance with a focus on quality and safety outcomes;
- Creating systems for openly communicating performance;
- Motivating individuals and teams to strive for excellence.

Case Study: Fostering a Culture of Accountability

Cahal manages a stroke unit at Antrim Area Hospital. His nomination for the Royal College of Nursing (RCN) Northern Ireland Nurse of the Year Awards 2024 focused upon his exceptional achievements in leading a team that has fostered a culture of accountability and improved patient safety and care standards by reducing in-patient falls.

The unit opened in March 2023 and Cahal led the building, motivation, support and development of the team. He identified staff involvement and engagement as key to managing the challenges and ensuring that the unit would be a success. His management is based upon staff engagement and training, prioritising staff health and wellbeing, embedding falls safety and prevention as part of the daily routine, promoting greater awareness of falls, and seamless engagement with the wider multi-professional team. Cahal's nurse-led initiative has improved patient outcomes by developing staff skills to meet in-patient needs, as well as by making it clear that preventing falls is 'everyone's business'.

As a consequence, the number of falls within the unit reduced by 43% within the first six months, with no catastrophic, major or moderate falls. Radiology requests reduced by 44%, with an estimated average financial saving of £2,240 over a six-month period. Staff retention and morale is at an all-time high, with Cahal ensuring that his team feels valued and appreciated.

Cahal's nominator stated: "Cahal has created an environment in which clinical excellence flourishes, ensuring high standards of patient-centred care. Cahal is a wonderful advocate and ambassador for patients, and this is just the beginning of his success."

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We are all accountable for our performance. There will be occasions when the performance of individuals or teams, fall below required standards. Suboptimal performance needs to be dealt with effectively, striking balance between supporting staff and keeping patients safe.

Where individual performance is of concern, managers should in the first instance adopt a supportive approach in order to seek early resolution. Managers should receive training and guidance on how to support staff with performance issues[8]. The majority of performance concerns should be managed and resolved informally between managers and employees, with advice sought from HR, when required.

Green Flag Leadership Behaviours for dealing with Poor Performance

Effective leaders do not unfairly apportion blame on individuals for poor performance but instead:

- Reflect on their role as leaders and how they can act differently to achieve better results;
- Engage with teams to actively listen, understand system issues or barriers that need rectified, and develop shared solutions;
- Respond compassionately to staff members who are suffering from burn out, moral distress, moral injury and trauma that may be impacting on performance – ensuring that support is provided;
- Provide support for individuals and teams to improve;
- Recognise that certain groups of staff, such as those who are newly qualified, or unfamiliar with the HSC Trust, i.e. locum and agency workers, may require enhanced support;
- Are prepared to have difficult conversations about improving performance in the interest of safeguarding patients from harm;
- Set targets and continue to monitor to ensure improvement occurs;
- If improvement does not occur, concerns are appropriately escalated to ensure enhanced scrutiny and additional support for improvement.

'Patient safety is paramount' and where there are 'Early Warning Signs' of a service in difficulty, the HSC Trust Board ensures that there is appropriate ownership for assuring and improving safety within the service, understanding ultimate accountability sits with HSC Trust Boards.[ix] Where Patient or Staff Safety is of significant concern, it may become necessary to invite independent assurance and secure external support for improvement.

[ix] The HSC Board Member Handbook supports Board Members in their oversight and assurance of safe, effective care.

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There will be occasions when the culture does not foster collective accountability for patient safety. The following 'Red Flag Behaviours' are indicators of poor practice; their presence warrants further exploration of the safety culture with a view to improvement.

Red Flag Behaviours

1. Taking unnecessary risks;
2. Failure to identify and address safety problems;
3. Individuals are blamed or punished for system failings;
4. Resistance to external scrutiny;
5. Failure to implement recommendations from scrutiny activity. (i.e. reviews, investigations, inquiries)

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Expectation 2: There is a ‘Floor to Board’ commitment to patient safety

2.1 Staff at all levels take responsibility for ensuring patients are safe. On a day to day basis, all staff advocate for their patients and act in their best interests.

2.2 Senior Leaders and Leaders and managers ensure there is robust safety promotion, communication and training throughout the organisation, in accordance with safety priorities.

2.3 Staff induction and staff development programmes, include safety issues pertinent to their role and service area. Refresh updates are provided at regular intervals in accordance with safety priorities and areas of risk.

2.4 Staff are clear on their roles and responsibilities, in respect of assessing and managing risk – the importance of which is clearly understood, and is not perceived as a ‘tick box’ exercise.

2.5 Staff at all levels understand the importance of good communication in ensuring patient safety. A structured approach to communication is adopted throughout the organisation, i.e. SBAR communication tools or equivalent.

2.6 Communicating concerns about patient safety risks is normalised within the day to day activities of the organisation. I.e. safety huddles or equivalent.

2.7 Staff at all levels, regardless of role or grade, feel safe and empowered to communicate concerns and contribute to discussions about patient safety issues.

2.8 Leaders and managers encourage teams to discuss and raise patient safety risks and concerns, and support teams to openly discuss and work together to address patient safety issues.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and Appropriate Management of Risk
DoH Quality Standard 5.3.3 Promoting Effective Care

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1.2 Patient Safety is everybody's responsibility

The founding principle of Health and Social Care is to provide care to patients and service users. Staff at all levels are responsible for keeping patients safe and always acting in their best interests.

Healthcare is complex and carries inherent risks to patients. Prevention of avoidable harm depends on staff having shared responsibility for keeping patients safe. **'From floor to Board, everyone plays an important role in patient safety'**. As such, all staff need to be empowered and enabled to act on patient safety concerns.

Where staff identify concerns that they cannot address by themselves, they raise these in the interests of safeguarding patients from harm – understanding that **'patient safety is paramount'** and **'we are all patient advocates'**.

Furthermore, we have a duty to listen, hear and act on safety concerns shared with us by others, understanding that **'we cannot un-know what we know'** and that we are all responsible for acting in the best interests of patients.

What good looks like: Communication

- Staff at all levels understand their roles and responsibilities with respect to effective communication;
- Staff understand the importance of good communication in ensuring patient safety;
- A structured approach to communication is adopted throughout the organisation;
- Tools are adopted to facilitate staff to communicate effectively. These may include:
  - SBAR tools;
  - standardised checklists;
  - proformas.
- Communicating concerns about patient safety is normalised within day-to-day activities including at the front-line, i.e. safety huddles, safety briefs, handovers, patient transfer etc.
- All staff, regardless of role or seniority, feel safe and empowered to communicate concerns and contribute to discussions about patient safety.

Communication within and between teams in crucial in maintaining patient safety. The vast majority of patient safety incidents involve failures in communication. It is important that the culture, and underpinning systems and processes, support robust communication between individuals, teams, services, Trusts and sectors, including the independent sector and primary care.

Good Practice Example

Improving Communication between Primary and Secondary Care

In 2019, Royal College of General Practitioners NI undertook a project to improve relationships between primary and secondary care – one of the main drivers was to improve patient safety.

This work led to the publication of a paper entitled 'Professional behaviours and communication principles for working across Primary and Secondary Care Interfaces in Northern Ireland'.[9]

The paper outlines 10 agreed principles to ensure better working together and was agreed by the medical Royal Colleges in NI as well as being adopted and published in the UK by the Academy of Medical Royal Colleges in 2020. It was a precursor to the January 2024 'Working Better Together' guidance, produced by HSCNI, which sets out a roadmap for working relationships between primary and secondary care.

This document has been adopted by both primary and secondary care, and its implementation is ongoing.

If implemented in full, it will go a long way towards improving the cultures and communications on the primary and secondary care interface, breaking down silos, and ultimately leading to better patient outcomes.

Unfortunately, in services with a poor safety culture, patient safety is not viewed as a priority; the following red flags are indicative of a culture where collective responsibility is lacking .

Red Flag Behaviours

1. **Poor communication:**
   - Silo working;
   - Lone working;
   - Dysfunctional teams;
   - Lack of a structured approach to communicating within and between teams
2. **Poor attitude to patient safety risks, such as:**
   - Complacency, manifesting as taking unnecessary risks
   - Denial of safety risks or problems
   - Failure to follow safety protocols, procedures and clinical guidelines
   - Refusal to engage in governance activities, such as clinical audit and safety improvement
3. **Failure to accept responsibility:**
   - Poor understanding of individual responsibility for identifying and acting on patient safety concerns
   - Lack of clear direction and accountability
   - Avoidance of taking responsibility

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Expectation 3: Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice

3.1 HSC Trust Boards and Senior Leaders demonstrate a commitment and strategic approach to reducing unwarranted variation in order to reduce: avoidable harm; health inequity; and waste.

3.2 Senior Leaders take measures to ensure that patients receive care in the right place, by the right person at the right time.

3.3 Assessment and treatment pathways are allocated in accordance with clinical need. Senior Leaders ensure that gate-keeping of resources for arbitrary reasons is avoided, and that clinical need takes priority.

3.4 Senior Leaders identify and address barriers to the delivery of safe, effective care in accordance with expected standards.

3.5 A person-centred approach is embedded throughout decisions for admission, diagnostic care and treatment pathways, patient transfer, and discharge home; where resources are limited, open and honest discussions with patients and families, along with a balanced discussion of risk.

3.6 Health and Social Care professionals at all levels receive training, support and guidance on ethical decision making and resource stewardship.

3.7 Senior Leaders embed evidence-based practice within HSC organisations by:

- Setting clear expectations that national and local guidelines should be followed;
- Ensuring effective systems in place for local guideline development.

3.8 There are effective systems for clinical audit, monitoring outcomes and seeking assurance on adherence to national and local standards.

3.9 Staff at all levels follow relevant national and local clinical guidelines. Deviation from standard practice only occurs for justifiable reasons, is discussed with patients and carers, and documented within the care records.

3.10 Staff are supported to keep up to date with their practice through dedicated time for in-house education and training, and to meet Continued Professional Development requirements.

3.11 Health and Social Care professionals work as part of teams, and where lone working is unavoidable, there are mechanisms for oversight and assurance, to protect patients from harm and provide Health and Social Care professionalswith support and guidance. I.e. MDT support; in-house supervision and peer support; support through regional networks; peer review.

DoH Quality Standard 5.3.3 Promoting Effective Care

1.3 Safe, Effective Care is underpinned by Evidence-Based Practice

Health and Social Care outcomes can vary in respect of quality, safety and experience. Such variation is common and can occur for acceptable reasons (known as 'warranted variation') such as population-factor variations such as differences in case-mix, clinical need and patient preference.

Unwarranted variation is variation that cannot be explained by such variations, and instead is caused by variation in service planning, design and delivery, workforce issues and variations in clinical practice.[10]

Whilst some factors, are outside the control of HSC Trusts (for e.g. service configuration), those which are within the sphere of influence of HSC Trusts should be appropriately identified and managed. Quality Management Systems[11] can support HSC Trusts to identify variation that can be controlled and moderated.

One factor within the control of HSC Trusts and Health and Social Care professionals themselves, is variation in clinical practice.

Variation in clinical practice can cause:

1. Avoidable harm;
2. Health inequity;
3. Waste of resource.

Meaning that:

- Some patients get the care they need;
- Others do not get the care they need;
- Some may even get care that they don't need, exposing them to unnecessary risk;
- At the same time, resources are unfairly distributed, contributing to overall inefficiency within the health service.

'Decisions around care should never be made based solely on preference of individual Health and Social Care professionals or individual HSC Trusts'.

Unless there is clear justification, which is discussed in partnership with patients and families, care should be appropriately evidence-based and adhere to relevant clinical guidelines.

It is acknowledged that at times equitable care delivery is not possible due to unremitting pressures, issues with access and resource constraints; for these reasons, Health and Social Care professionals need to be supported with ethical decision making and resource stewardship.

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Expectation 4: Tackling health inequalities is a key safety priority

4.1 HSC Trust Board and Senior Leaders demonstrate a true commitment and strategic approach to tackling health inequalities and addressing disproportionate levels of healthcare-related harm experienced by underrepresented groups.

4.2 From 'floor to Board', health inequalities are considered on the safety agenda at all levels within the organisation.

4.3 Senior Leaders proactively engage with advocacy representatives, local communities and the community and voluntary sector to understand quality and safety of health and social care services, including for underrepresented groups, in order to identify opportunities for improvement.

4.4 Data is monitored on demographics, population need and patient experience; utilising this for service planning, design, development and improvement with a view to tackling health inequalities.

4.5 Feedback is proactively sought from under-represented groups to enhance an understanding of how these groups experience health and social care services.

4.6 There is role-dependent training and awareness raising for staff on how to provide care to service users and families from a range of backgrounds, including cultural diversity, social complexity; and other protected characteristics such as disability, depending on case-mix of specific service populations.

4.7 Staff at all levels demonstrate an understanding of health inequalities as a safety priority, and can describe how health inequalities are being identified and tackled within their own service area.

4.8 Training for staff on improving outcomes for people with poor Health Literacy.

4.9 There is effective multi-agency working to improve outcomes for people with vulnerability factors.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.4 Tackling Health Inequalities

HSC Trusts have a statutory duty to reduce health inequalities within the populations they serve.[x]

All people are adversely impacted when their needs are not met. However, for certain groups, by virtue of intersecting characteristics and overlapping vulnerabilities, the impact is compounded.

Within the NI population, there are high levels of socioeconomic deprivation, conflict-related and intergenerational trauma[12], childhood adversity and ongoing community tensions. All of these have adversely impacted on the vulnerability of the population, including on levels of health literacy and health empowerment, which co-exist alongside remnants of a paternalistic mindset within HSC.

Furthermore, we know that structural bias and discrimination contribute to ongoing inequality within our society. People from underrepresented groups may be impacted by social determinants of health, experiencing lower attainment of education, employment and income, poorer housing, less access to green spaces, social deprivation; all of which can contribute to poorer mental and physical health outcomes. It is an unfortunate reality that **'someone's postcode can have more influence over their health than their genetic code'.**

Over the past decade, the NI population has become more ethnically diverse; amongst immigrant populations, which includes asylum seekers and refugees who may be fleeing conflict or persecution in their home country, there is a high prevalence of trauma, social complexity and mental health need.[13]

There may be additional barriers in accessing HSC services due to immigration status and perceptions around payment, cultural and language differences, limited access to technology, precarious employment, travel costs and difficulty securing childcare.

Furthermore, people from underrepresented groups may have a poorer experience of healthcare services due to biases within service design and clinician-patient interactions. At its worst, patients from underrepresented groups, experience disproportionate levels of healthcare-related harm.[14]

For this reason, health inequalities should be on the safety agenda at all levels of the organisation, including in interactions with external stakeholders at policy, commissioning, public health level, and also in engagement with the community and voluntary sector, understanding that a whole system approach is needed to drive improvements in outcomes.

[x] Health and Social Care (Reform) Act (Northern Ireland) 2009 places a duty on each HSC trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing health inequalities between, those for whom it provides or may provide health and social care.

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Case Study: Tackling Health Inequalities

Cathy practises as a clinical pathway nurse in unscheduled care and has developed and led the Care Navigator Project within the emergency department at the Ulster Hospital. Her nomination for the Royal College of Nursing (RCN) Northern Ireland Nurse of the Year Awards 2024 focused on her firm commitment to tackling health inequalities.

Patients attending emergency departments may have complex social issues with which Health and Social Care professionals are often not equipped to assist. This can leave patients vulnerable and may lead to increased attendances as complex issues are unable to be addressed.

Cathy provides preventative and early interventions to support marginalised patients and thereby help tackle health inequalities. This can have a positive impact on their overall health and wellbeing. In January 2023, the ten most frequent attenders recorded a total of 36 presentations to the emergency department. Following care navigator input, this reduced by December 2023 to just two attendances.

Cathy has led in building partnerships with over 30 different voluntary and community networks to access a variety of different services that can offer ongoing support. She acts as an advocate for patients and is extremely supportive to her team, providing regular caseload review meetings and debriefing when required. Cathy has developed a referral pathway for unscheduled care that enables nursing and medical teams to refer to the service. She also delivers teaching to medical and nursing staff regarding the service, which increases awareness throughout the directorate.

Cathy's nominator stated: "[Cathy's] passion and dedication to provide a service that ensures person-centred therapeutic interventions, improving the social, mental, physical and emotional wellbeing of patients, is inspiring."

Expectation 5: Staff are nurtured, supported and enabled to fulfil their potential

5.1 There is a shared vision for Patient and Staff Safety and Wellbeing, understood by staff working at all levels, that is underpinned by staff wellbeing as a core organisational value.

5.2 There is a shared ethos of 'we look after our staff so that they can look after their patients', understanding the intrinsic link between staff wellbeing and patient safety.

5.3 DoH Health and Wellbeing Framework 2025 is utilised for planning and implementing effective processes and resources for improving staff health, wellbeing and safety.

5.4 Leaders and managers work to optimise staffing levels, rota patterns, workloads and team relationships, in order to prevent burn out, work-related stress, staff ill-health and sickness absence.

5.5 There is a pro-active approach to maintaining safe staffing levels and skills mix within services. This includes: ensuring timely recruitment, effective succession planning, maximising skill mix of the current workforce, and clear mechanisms to escalate concerns about safe staffing.

5.6 Leaders and managers support staff to escalate concerns about staffing levels; when concerns are raised, these are listened to and acted upon.

5.7 When the funded capacity and capability of services is insufficient to safely meet the needs of the patient population, leaders escalate concerns to commissioners.

5.8 Line managers receive training and support in order to adhere to NICE Guidance NG13: Workplace health: management practices.[15]

5.9 Staff at all levels report that their safety and wellbeing is an organisational priority and that leaders and line managers are sensitive to core needs of Autonomy, Belonging and Contribution.

5.10 There are pro-active mechanisms to support staff wellbeing, such as Schwartz groups; mentorship; coaching; forums for peer support; and Health and Wellbeing Initiatives.

5.11 There is access to clinical psychology for staff trauma from moral injury, incidents, unhealthy workplace cultures.

5.12 There are arrangements in place for monitoring staff wellbeing across HSC services.

5.13 Where wellbeing issues are identified, leaders are supported to engage with teams to understand concerns and work together to identify practical solutions to improve working conditions.

5.14 When issues with morale, burn out and moral distress and injury within HSC services are identified, improvement plans are put in place to improve working conditions, address the wellbeing needs of staff and ensure safe service provision.

5.15 Senior leaders are committed to developing a confident and capable workforce. Staff and teams at all levels are empowered and enabled to fulfil their potential.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.5 Staff Wellbeing is a Core Organisational Value

Patient Safety is inextricably linked to staff wellbeing. Healthy, happy staff are better able to provide high-quality patient care. Conversely, staff who are demoralised, burnt out or suffering from moral distress and injury are not going to be able to provide the safe, compassionate care that we would want to see and receive.

'We must look after our staff so that they can look after their patients'.

NHS staff across the UK report higher levels of work-related stress, anxiety and depression than staff working in other sectors.[16] Rates of sickness absence are at an all-time high as well as the numbers of staff considering leaving the NHS. The harsh reality of mental health impact is reflected in stark statistics: one nurse completes suicide every week and one doctor every three weeks.[17]

Unfortunately, for staff wellbeing within HSC, Northern Ireland fares no better – and may even be worse.

In August 2025, the GMC published its findings on Workplace Experience.[18] Across the following metrics, doctors in NI reported significantly more negative experiences than the UK average:

- 73% working beyond rostered hours on a weekly basis (UK average 62%);
- 26% are at high risk of burn out (UK average 18%);
- 23% are 'doing well' with managing workloads (UK average 31%);
- 54% found it difficult to provide sufficient patient care at least once a week (UK average 40%);
- 69% experienced barriers to patient care, such as delays in care and treatment, investigation and screening (UK average 57%);
- 56% experienced poor organisational leadership – defined as, poor management communication, and lack of support (UK average 45%).

These figures indicate that a substantial proportion of NI medical staff are over-worked, at risk of burn out, struggling to provide sufficient patient care, and experience poor communication and lack of support from organisational leaders.

As the HSC Staff Survey has not run in recent years, there are no comparable results for other staff groups. Albeit, qualitative data from reports such as Royal College Nursing (RCN) Corridor Care Report[19], includes concerning statements from NI nurses:

> *"We lose sleep worrying about people, we lose love of the job. It's affecting our family lives because we are so unhappy in our work environment, and we take it home."*

> *"The moral injury is immense. I cannot provide the care I want to provide or the care my patients deserve. It is exhausting and demoralising. Within this last six months... I have thought more and more about leaving the [nursing] profession. In the previous seven years this never crossed my mind."*

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It increasingly clear that there cannot be a true commitment to patient safety without also committing to maximising staff health and wellbeing.
'Staff need to be held.'

Research by the King's Fund[20] indicates that staff have three core needs:

- **Autonomy** – the need to have control over their work lives, and to be able to act consistently with their values;
- **Belonging** – the need to be connected to, cared for, and caring of others around them at work, and to feel valued, respected and supported;
- **Contribution**– the need to experience effectiveness in what they do and deliver valued outcomes.

All three of these must be met for people to flourish and ensure staff are **'thriving, not just surviving'.**

It is difficult for staff needs to be met when staffing levels are suboptimal, which increases workload, work-related stress, and tension within teams. It is well established that services with staffing shortages have higher incidence of poor staff wellbeing, burn out, illness, and cultural problems such as incivility and bullying, as well as higher patient safety incidents. **'Staffing levels must not be used to excuse poor safety culture'**, but rather should be addressed as a modifiable cause.

In addition to ensuring safe staffing levels, staff as individuals need to be enabled to meet their potential and be the best that they can be.

What good looks like: Enabling Staff to Fulfil their Potential

- Leaders and managers act as role models and seek out opportunities to champion, advise and teach their teams;
- Staff are provided with open and constructive feedback on performance including on living the HSC values;
- Staff are supported to keep up to date with their practice through dedicated time for in-house education and training, and to meet Continued Professional Development requirements;
- There is time and space for staff at all levels to learn together, including multidisciplinary teams;
- Staff are valued, recognised and appreciated for their skills, attributes and efforts; with particular focus on praising and rewarding attributes and behaviours consistent with HSC values.

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Red Flag Behaviours

1. **Hierarchical mindsets**
   - Command and control style leadership;
   - Micromanagement;
   - Language used in staff communication is authoritarian.

2. **Undervaluing staff**
   - Staff are seen as bodies to fill posts;
   - Poor investment in staff training and development.

3. **Failure to support staff**
   - There is a lack of empathy and compassion for staff;
   - Staff support is minimal or tokenistic.

4. **Failure to address wellbeing issues**
   - Incivility and bullying goes unchallenged;
   - High sickness absence and staff turnover;
   - Lack of curiosity around sickness absence and how improve staff wellbeing.

Expectation 6: Diversity is welcomed, championed and supported, understanding that it makes teams more effective

6.1 Diversity is welcomed and championed by Leaders through-out the organisation. There is a shared understanding amongst staff at all levels that diversity makes teams, services and organisations more effective.

6.2 Staff at all levels seek out and welcome the views of others, valuing different perspectives and lived experiences.

6.3 Everyone within a team, regardless of characteristics, role or grade, has an equal voice and is actively enabled to use it.

6.4 Staff members who are new to NI are consistently welcomed, included and supported as valued members of HSC teams.

6.5 All members of teams are supported to have a sense of belonging; there is mentorship and peer support in place for staff members from underrepresented groups.

6.6 Leaders and managers seek to maximise the strengths and talents of all team members. Training and development opportunities are offered on a fair and equitable basis; and accessible to all. For e.g. online training takes account of accessibility needs.

6.7 Leaders and managers provide timely support for staff with disabilities and additional needs.

6.8 Line managers ensure prompt access to occupational health and timely implementation of reasonable adjustments.

6.9 There are mechanisms to ensure inclusive recruitment and enhanced support for staff from underrepresented groups, including those who are new to NI.

6.10 There are mechanisms in place to capture feedback from a diverse range of voices within HSC workforce, including under-represented groups; this is used to drive improvements in organisational culture with respect to 'equality, diversity and inclusion'.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.6 Equality, Diversity and Inclusion

The HSC workforce is becoming more diverse. This is a strength – **'Diversity makes us smarter'**. A group of human minds has greater capability and agility than a single mind, and even more so, when that group is able to bring a variety of perspectives and experiences, avoiding the common pitfall of 'group-think'[21].

All staff deserve to be valued, respected and supported - we should be particularly thankful those who have made significant efforts, often facing considerable challenges, in order to work as part of our HSC system - including staff who have travelled from their home countries.It is an incontrovertible truth that HSC would not be able to function without the support of our colleagues from overseas, along with colleagues from other underrepresented groups.

Therefore, it is a sad indictment that Health and Social Care workers from underrepresented groups experience poorer physical and mental health outcomes than their counterparts; some of which can be attributed to discrimination, bullying and harassment within the workplace.[22]

This is an intolerable situation that not only impacts on the safety and wellbeing of HSC staff, but also has a significant impact on service provision and the quality of care that can be delivered to patients.

Patient safety issues, sickness absence, and staff turnover are more prevalent in organisations that fail to tackle workplace cultures which enable and reinforce disparities across different groups of staff.

Conversely, organisations that are inclusive, champion diversity and promote belonging, are more likely to succeed in empowering their staff to thrive, fostering psychological safety and improved staff wellbeing. As well as harnessing benefits from diversity of thought, to drive creativity and innovation, and deliver high-quality patient care. **'Diversity makes us more effective'**.

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Expectation 7: Voices of staff, patients and families are embraced as an important barometer of safety

7.1 Feedback from staff is highly valued, encouraged and utilised to drive meaningful change.

7.2 There is a pro-active approach to gathering feedback from staff via a range of mechanisms: Leadership Walk-Rounds[23], staff surveys, forums, focus groups, story boxes etc.

7.3 HSC Trust Board Patient Safety and Quality Committee have oversight of assurance data which includes both quantitative and qualitative data from staff feedback, integrating this with a range of other indicators.

7.4 The voices of staff are given due attention, recognising that staff can effectively identify issues with quality and safety, and tend to have a high threshold for escalating concerns.

7.5 Feedback from patients and families is highly valued, encouraged and utilised to drive meaningful change.

7.6 There is a pro-active approach to gathering feedback from patients and families from a range of mechanisms: surveys; engagement forums; advocacy and participation; Care Opinion; Patient and Client Council; Community and Voluntary Sector; Complaints

7.7 There is a commitment to learning from the voices of patients and families at all levels within the organisation.

7.8 Clinical and governance team meetings openly discuss and learn from patient and family voices, including feedback and complaints.

7.9 Patient and family stories are regularly included as part of staff education and safety improvement programmes.

7.10 Testimonies from patients, victims and families who have been harmed by healthcare are welcomed, graciously accepted, and utilised to drive improvements at all levels within the organisation.

7.11 HSC Trust Board Patient Safety and Quality Committee Assurance Reports, include qualitative and quantitative data from patients and family feedback.

7.12 HSC Trust Boards and Senior Leaders value the voices of patients, families and staff, and consistently integrate these with a range of meaningful safety indicators to provide a reliable understanding of safety performance.

7.13 HSC Trusts harness the power of data analytics and expert advice on quality and safety to develop a reliable understanding of where the key safety priorities lie and how to address them.

DoH Quality Standard 5.7.1 Ensuring Safe Practice and the Appropriate Management of Risk

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1.7 Staff, Patient and Family Voices

Staff, patient and family voices are highly valuable to organisations in the assessment of safety; whilst quantitative feedback can be triangulated with other indicators to provide 'early warning signs' of safety issues within HSC services, qualitative feedback is incredibly rich, can provide nuance, and valuable insights into how to drive improvement.

Patients and families may recognise problems within HSC services long before they are identified on performance dashboards. By valuing patient and family voices and acting on concerns at an early stage, through routinely using patient and family stories to educate staff and inform service improvements, safety can be enhanced prior to the emergence of more serious concerns. Through **'listening, hearing and acting we can avert crisis'**.

Equally, the voices of staff should be given due attention, recognising that staff often have a high threshold for 'putting their heads above the parapet'. Staff can also help to identify problems before harm occurs; **'listening and acting on staff concerns is an important mechanism to prevent patient harm'**.

It is not just substantive staff that can provide a helpful insight, locum/agency workers, resident doctors and HSC students, may offer a unique perspective, by virtue of rotating through different HSC services and Trusts. Mechanisms should aim to capture feedback from all willing contributors.

Where the voices of patient, families or staff, paint an alarming picture, HSC Trust Boards should undertake a 'deep dive' to explore issues with staff and patient safety, and where safety concerns are identified, appropriate and early action should be taken to safeguard patients and staff from harm.

Importantly, when such information received from patients, families and staff has been used to drive improvements in patient safety- improvement efforts, along with any outcomes, should be shared with those who raised concerns – maintaining feedback loops.

By encouraging and supporting staff, patients and families to provide feedback, and valuing it is an important barometer of safety, not only do we demonstrate a commitment to learning and improvement, but we also foster trust and confidence amongst the workforce, patients and the public by showing - **'Your voice matters, you will be listened to and you can make a valuable contribution to improving patient and staff safety'**.

Even more so, when staff, patients and families who have raised concerns are offered an opportunity to contribute to improvement, as set out in the case study below.

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Case Study: Listening to Family Voices to Improve Patient Safety

My Mum suffered avoidable harm following a fall in the Nursing Home.

She was left on the floor for 11 hours because she was on Warfarin and the Nursing Home staff were awaiting advice from the Ambulance Crew who were unavailable to attend.

The Ambulance Crew eventually attended and lifted her off the floor but unfortunately by this time my mum had already vomited and aspirated, leading to a lung infection.

I had a meeting with the Nursing Home Managers, COPNI, the Trust Social Worker and our GP afterwards. We persuaded Management that learning was all we wanted from this, not blame – we just wanted to ensure that this never happens to anyone again, that long lie risks and consequences would also be considered and not ignored in the future.

I raised this with the Chief Nursing Officer at the time and I became involved in a Regional Falls initiative with Public Health Agency, DoH, NI Ambulance Service etc. This took a lot of learning from this incident and will hopefully ensure that this never happens to anyone again.

Expert by Experience

Patient and family voices by themselves, can be powerful and compelling outlining the real-life impact of failings in care delivery, governance and culture. When patient and family testimonies are included as part of staff education and safety improvement programmes, it can greatly enhance staff learning and serve to drive improvements in clinical practice.

The Regulation and Quality Improvement Authority

HSC Health and Social Care

Changing the Culture through Education and Training

Stephen's Story, as told by his Mother Norma Sparkes[xi] is the central thread to 'Building a Safe and Compassionate Culture within Health and Social Care' eLearning programme.

The programme, developed through co-production, led by RQIA and in collaboration with Leadership Centre and other key stakeholders, is part of RQIA Legacy Commitment work to drive improvements in safety culture within HSC, following learning arising from Expert Review of Records of Deceased Patients of Michael Watt.

The Programme, available on LearnHSCNI on this link, covers the following topics:

- Evidence-based practice
- Person-centred care
- Listening, Hearing and Acting
- Candour
- Creating Safe and Compassionate Cultures for Health and Social Care professionals
- Governance

2 CPD Points

It is valuable to Health and Social Care professionals from all disciplines and at any stage of their career, from undergraduate level, right up to retirement.

SCAN ME

[xi] Norma Sparkes' son, Stephen Sparkes, is deceased a patient of Michael Watt. Since Stephen's death, Norma has advocated for improvements in Patient Safety within the Health and Social Care System in NI.

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Domain 1: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Health and Social Care (Reform) Act 2009;
- Human Rights Act 1998;
- Disability Discrimination Act;
- Health and Safety at Work (NI) Order 1978;
- DoH Collective Leadership Strategy;
- NHS England Framework for involving patients in patient safety;
- NICE Guidance NG13. Workplace health: management practices;
- NICE Guidance NG212. Mental Wellbeing at Work;
- NHS England. Health and Wellbeing Framework;
- NHS England. Civility and Respect;
- NHS Resolution. Just and Learning Culture Charter.

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Cultural Domain 2: Compassion, Civility and Respect

Domains	Themes	Expectations
Compassion, Civility and Respect	**Leading with compassion**	Compassionate Leadership is fundamental to all other aspects of a safety culture.
	Empowering staff, patients and families	Effective Teamwork and Psychological Safety is nurtured within Teams.
		Staff at all levels are kind and civil and work within 'Safe and Compassionate' teams.
		Patients and Families are Empowered, Enabled and Informed.
	Enhancing openness, trust and mutual respect	Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues.
		All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions.
		Openness and candour is promoted and supported at all levels in the organisation.

Expectation 8: Compassionate Leadership is fundamental to all other aspects of a safety culture

8.1 Collective Leadership[xii] is embedded within the organisation.

8.2 HSC Trust Executive Teams and Senior Leaders ensure leadership responsibility is appropriately distributed throughout the organisation, valuing and respecting the contribution and autonomy of staff working at all levels.

8.3 HSC Organisations recruit, develop and nurture inclusive, compassionate leaders who live the values of HSC. This is supported by:

- Values-based recruitment and succession-planning into Senior Leadership commitment;
- Values-based appraisal;
- Leadership Training and Development;
- Mechanisms, such as 360-degree feedback, coaching and mentoring;
- Time and space for Senior Leaders to reflect, learn and improve;
- Accountability for Senior Leaders who do not behave in ways aligned to HSC values.

8.4 Senior Leaders role model behaviours of careful listening; understanding; empathising; and supporting other people;

8.5 The performance of leaders, at all levels, is assessed by the extent to which their behaviours align with HSC values and by their contributions to supporting staff wellbeing and patient safety;

8.6 Leaders and managers demonstrate an understanding that trusting relationships are crucial to patient safety, and strive to meet the core needs of staff in relation to Autonomy, Belonging and Contribution;

8.7 There is training and support for line managers in people management skills, including informal approaches to supporting staff in difficulty, without overreliance on HR procedures;

This includes:

- Supporting staff with wellbeing issues;
- Handling sensitive situations / having difficult conversations;
- Managing performance issues;
- Managing incivility and conflict;
- Early resolution to concerns.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

DoH Quality Standard 8.3 Effective Communication and Information

[xii] The HSC Collective Leadership Strategy promotes shared, collaborative and compassionate leadership in and across teams, and across the HSC system

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2.1 Compassionate Leadership

'Culture comes from the top' We know that leadership is the single most influential factor in shaping organisational culture – therefore some of the most impactful decisions made within HSC are about recruitment into senior leadership positions.

Senior leaders set expectations and role model the values and behaviours essential for a healthy workplace culture. The espoused values, behaviours and actions of senior leaders can have a profound impact on organisational performance with respect to: staff wellbeing, psychological safety, civility, just and open culture; and patient safety outcomes.

Safe, effective organisations are led by compassionate leaders who:

- **Listen carefully;**
- **Understand;**
- **Empathise;**
- **Support Others.**

Being Human

In many respects, compassionate leadership is about 'being human'.

It involves:

- Creating time and space for authentic human connection;
- Developing trust and confidence amongst staff;
- Understanding that missed deadlines, mistakes and performance issues can arise from hidden suffering;
- Noticing, inquiring about and taking action to lessen suffering or distress of others;
- Valuing different views and perspectives;
- Being curious about the experiences of others;
- Commitment to equality, diversity and inclusion;
- Giving dignity and worth to people whatever their role, grade or background;
- Providing support and acting in ways that are altruistic for the benefit of others;
- Withholding blame and focusing on learning, supporting and improving;
- Avoiding rigid process-driven, legalistic or defensive approaches that inhibit human connection;
- Addressing toxic workplace cultures and unhealthy or harmful behaviours by deploying kindness and compassion.

It is important to note that compassionate leadership does not mean 'being nice'. It means being fair, open and honest, and having the tenacity to **'do the right thing'** – which can include making unpopular decisions and holding others to account for their behaviour in the interests of patient and staff safety.

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Compassionate leadership is not an optional 'nice to have', it is essential – it should be a reality that **'compassionate leadership is part of the fabric of our HSC system'**.

For the most senior positions within HSC, only those with a proven track record of leading with care, fostering staff wellbeing, psychological safety, just and open cultures, should be considered for the job, understanding that **'Staff Wellbeing is a Core Value'** and **'Patient Safety is Paramount'**.

Compassionate Leaders do...	Compassionate Leaders do not...
Believe everyone plays an important role and it is their job to support and enable staff to do well.	Believe that they are the most important person in the room and people must admire and obey them.
Be visible and approachable.	Be inaccessible or evasive.
Distribute power to others, enabling staff to have autonomy and control over their work.	Micromanage, or operate a 'command and control' style of leadership.
Believe that patient safety is paramount, and staff wellbeing is a core organisational value.	Put personal or organisational reputation or finances before the safety of patients and staff.
Do not have all the answers; have humility and accept fallibility.	Believe that they have all the knowledge.
Create time and space for teams to come together.	Create unsustainable work pressures with no time for team building or reflection.
Enjoy listening to others and are happy to take a back seat to allow others to flourish.	Do all the talking and monopolise team meetings.
Demonstrate zero tolerance for harmful and abusive behaviour.	Themselves engage in bad behaviour.
When things go wrong, respond fairly with compassion and focus on restoration, learning and improvement.	Blame staff for honest mistakes.
Encourage staff to speak up and have genuine appreciation and support for those who do.	Pose a risk to those who speak up by seeking to ignore, punish or retaliate.

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Case Study: Compassionate Leadership within North West Cancer Centre Radiotherapy Outpatients

Paula is the Treatment Lead Radiographer in North West Cancer Centre. Paula leads a team of 30-40 multidisciplinary staff who deliver radiotherapy outpatient services. Paula's commitment to compassionate leadership is exemplified through her approach to staff management:

Person-centred approach: Paula views staff holistically, considers what other pressures they are under, along with what support is required by their line manager.

Understanding what is important to staff: Staff polls, 1-2-1s and group interviews are undertaken to find out what is important to staff and consider what changes could be made to improve the working environment.

Implementing shared solutions: Paula is committed to implementing shared solutions. For example - As a result of staff feedback, flexible working has been adopted by the team. Each request is viewed on an individual basis - Paula always starts from a positive place of how can they make this work for the staff member and service. Paula describes that it is not always about saying yes but it is about being prepared to have compassionate and sometimes difficult conversations, allowing for follow-up and creating alternative solutions together.

Focus on staff wellbeing: Paula is trained as a coach and encourages Take 5 principles and reset during the working day. Through this approach she knows her staff well and can pre-empt situations which allows her to intervene early, listen to them and offer advice and support. Paula strongly encourages staff to access other Trust resources available, i.e. health and wellbeing initiatives and psychological support when needed

Encouraging Peer Support: The team supports each other using their skills and interests, for e.g. crochet, book clubs and a project on exercise to motivate staff to move.

Staff Development: There is a clear focus on career progression and staff development with staff encouraged to access HSC/CEC courses, as well as supporting their CPD.

Encouraging staff to speak up: Paula has an 'open door' policy. This open, supportive approach is replicated throughout the team.

Outcomes

- The department have lower sickness absence rates, high retention of staff and a waiting list of staff wanting to join their department;
- The staff support each other and are passionate about their patients and service;
- There is increased willingness to provide short notice cover when its required;
- There is an excellent patient care record within the department with over 500 pieces of patient feedback each year. The department has not received a patient complaint in over three years.

Conclusion

Through Paula's compassionate and supportive leadership there have been tangible benefits for staff and patients. This approach to listening, understanding, empathising and supporting staff is amenable to 'scale and spread' across the region.

Expectation 9: Effective Teamwork and Psychological Safety is nurtured within Teams

9.1 HSC Trust Boards and Senior Leaders role model compassion, inclusivity, humility, and curiosity in order to foster psychological safety within teams and within their interactions with staff at all levels.

9.2 There is training and awareness for leaders on psychological safety, civility and human factors.

9.3 Leaders and managers create psychologically safe environments by encouraging staff to contribute, suggest ideas, ask questions, raise concerns.

9.4 There are psychologically safe and inclusive forums for staff to suggest ideas and raise concerns.

There are forums for teams to meet regularly to:

- learn together;
- discuss learning and feedback from governance activities;
- discuss service development and improvement.

9.5 Staff, of all backgrounds, roles and grades, feel psychologically safe to contribute to discussions, suggest ideas, ask questions, raise concerns.

9.6 Effective multidisciplinary working is valued at all levels within the organisation.

9.7 Barriers to effective team functioning, such as incivility, bullying, harassment and discrimination, are quickly identified and addressed.

9.8 Leaders are proactive about supporting teams to work well together, such as ensuring:

- common purpose;
- clearly defined roles and responsibilities;
- opportunities for team building and to foster camaraderie;
- multi-professional learning;
- time to reflect together.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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2.2 Psychological Safety within Teams

'Effective teamwork is essential for safe patient care'. Conversely, when teamwork is lacking or when there are interpersonal tensions between team members - patient safety is put at risk.

Teams should have common purpose, role clarity, appropriate skill mix and effective communication but just as important are:

- **belonging;**
- **mutual respect;**
- **civility; and**
- **psychological safety.**

Psychological safety is defined as a "shared belief held by members of a team that the team is safe for interpersonal risk taking".[24]

The Institute for Health Improvement describes four attributes of psychological safety:[25]

1. Anyone can ask questions without feeling stupid;
2. Anyone can ask for feedback without looking incompetent;
3. Anyone can be respectfully critical without appearing negative;
4. Anyone can suggest innovative ideasAwithout being perceived as disruptive.

By anyone, this means any team member. **'We all play an important role in keeping patients safe – therefore we all need to feel safe to be heard'**.

Feeling safe is not the same as feeling comfortable and, in many respects, psychological safety is about **'feeling safe enough to have the uncomfortable conversations'**, without fear of negative repercussions.

Achieving Psychological Safety can be a journey and within high-pressured HSC environments requires a concerted effort.

A measure of success is when the **'quietest voice in the room feels safe and enabled to be heard'**. The quietest voice may be the newest team member; most junior team member; the non-clinician amongst a team of Health and Social Care professionals; a team member from outside of Northern Ireland; or team members from an underrepresented group – which is why the foundational stage of psychological safety is inclusion and ensuring that everyone feels a sense of belonging. **'Equality, Diversity and Inclusion is not a 'nice to have' - it is essential for patient safety'**.

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The four stages of psychological safety:[26]

1. Inclusion safety: lays the foundation for psychological safety by ensuring everyone feels a sense of belonging;
2. Learner safety: allows staff to make mistakes, ask questions and seek feedback without fear of negative repercussions;
3. Contributor safety: emerges when staff feel confident in sharing ideas and participating fully in their roles;
4. Challenger safety: the pinnacle of psychological safety. Staff feel secure enough to question the status quo, propose new ideas and offer constructive feedback.

The next stage of psychological safety is giving people safety to learn by encouraging them to ask questions, by not punishing mistakes and allowing staff to seek feedback without fearing repercussions.

As psychological safety grows within the team, staff will become more confident to contribute, fully participate in discussions and share ideas – this fosters creativity and innovation. It is hoped that at this stage, staff (regardless of role or grade) will also feel confident to raise concerns about patient safety.

However, the pinnacle of psychological safety is described as 'challenger safety' when staff feel safe to constructively challenge – this may involve a junior member of the team challenging a consultant when they are concerned that a patient safety issue has been overlooked.

The complex nature of healthcare means that prevention of avoidable harm can depend on timely intervention from any member of the team, of any role or grade. When this valuable safeguard is removed due to hierarchy or a lack of psychological safety, healthcare is intrinsically less safe.

Senior members of teams need to take the lead in flattening the hierarchy, fostering psychological safety for the quietest voice to challenge, and role modelling the behaviours that allow psychological safety to flourish.

Green Flag: Leadership behaviours for psychological safety

- Flattening the hierarchy;
- Champion and welcome diversity;
- Role model compassion, inclusivity, and humility;
- Embed processes to promote inclusion, contribution and challenge;
- Ensure effective multi-disciplinary team working;
- Recognition, appreciation and valuing of all staff;
- Zero tolerance for harmful behaviour;
- Tackle incivility.

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Case Study: Fostering Psychological Safety within Belfast HSC Trust Maternity Services

In response to the findings of the Ockenden Inquiry report and the 2022 Belfast Trust Staff satisfaction survey, the Belfast HSC Trust Maternity Department has taken the decisive steps to foster a psychologically safe, just and learning culture across the service.

Key initiatives have included:

Promotion of Teamwork and Civility

- Confidential listening groups helped understand frontline challenges; these informed subsequent improvements;
- 'Growing a Culture of Kindness' initiative promotes multidisciplinary collaboration, reducing inter-professional barriers through principles of civility and respectful challenge.

Staff Training

- All new staff members receive training in human factors and just culture principles such as respectful challenge, civility and safe escalation;
- Royal Jubilee Maternity Service (RJMS) revised its fetal monitoring training from a half-day ad-hoc session to a full-day structured mandatory program, incorporating human factors, just culture, and psychological safety

Supporting Communication and Escalation

- ·"Team of the Shift" initiative, aligns staff names and roles at each medical handover to strengthen familiarity and teamwork;
- Visibility of team members is enhanced by photo posters displaying current medical and anaesthetic personnel.

Supporting safe and compassionate midwifery practice

- Counselling for women choosing care outside national guidance, led by senior midwives, with cases reviewed at weekly MDT meetings;
- Specialist legal training for midwives on homebirth care, ensuring legally sound practice.

Learning and Improvement

- Adoption of HSIB methodology in SAIs to focus on learning rather than blame, with positive feedback from both the Trust and DOH;
- The Maternity Learning and Improving Group (MLIG) integrates insights from serious adverse incidents (SAIs), Stillbirth Working Group, and Datix alerts into shared learning updates.

Together these initiatives represent a proactive, department wide approach to building a culture rooted in safety, compassion and learning.

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Red Flag Behaviours

1. **Lack of inclusivity**
   - Hierarchical attitudes;
   - Newcomers are not welcome.

2. **Poor behaviour**
   - Incivility;
   - Bullying.

3. **Dysfunctional team working**
   - Conflict;
   - Poor multidisciplinary working;
   - Tribalism.

4. **Challenge discouraged**
   - Low rates of constructive challenge;
   - Unfair treatment of staff who constructively challenge.

Expectation 10: Staff at all levels are kind and civil and work within safe and compassionate teams

10.1 Teams experience safe and compassionate working environments, where leaders and colleagues are civil and kind, and harmful behaviours such as incivility are addressed and eradicated.

10.2 HSC Trust Boards and Senior Leaders set clear expectations for staff in respect of values and behaviours consistent with a positive workplace culture.

10.3 Staff at all levels understand the values and standards of behaviour to which they are expected to demonstrate and for which they will be held accountable.

10.4 Line Managers at all levels are provided with training and support to deal with behaviours that are not consistent with the values of HSC.

10.5 There is training and awareness raising for staff on the importance of professionalism, civility and effective teamwork.

10.6 Staff at all levels demonstrate an awareness that incivility is patient safety issue, impacting significantly on cognitive performance, decision making and team functioning.

10.7 Awareness raising on Incivility, such as 'Civility Saves Lives', is embedded within the organisation.

10.8 Incivility is called out and resolved through appropriate interventions, which may include team engagement, mediation, negotiation, identification and mitigation of stressors, and holding individuals to account for their behaviour.

10.9 Leaders and Line Managers at all levels are trained and supported to understand the difference between incivility and team conflict that arises because of situational stressors - and bullying, harassment and discrimination which is intentional and deliberate.

10.10 Bullying, harassment and discrimination of any kind is appropriately identified and dealt with via HR procedures.

10.11 Individuals are held to account for their behaviour and where a case of bullying and harassment is upheld, serious consideration is given to whether such individuals should manage staff going forward in accordance with HR procedures. Understanding that clear parameters, conditions and evidence of reform should be required before these staff members are assigned line management responsibility.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

DoH Quality Standard 8.3 Effective Communication and Information

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2.3 Tackling Incivility and Eradicating Harmful Behaviour

Staff behaviours within the workplace are an inherent manifestation of any culture and form an integral part of how workplace environments are experienced and perceived.

Unkind or uncivil behaviour is not only unprofessional and unpleasant; it is a serious patient safety issue. **'Incivility costs lives'** – a fact substantiated by research and forms the premise of the Civility Saves Lives Campaign.[27]

Uncivil behaviour between colleagues results in a significant reduction in cognitive ability in both recipients and witnesses, impacting on clinical decision making and increasing the chances of medical error and patient harm.

Furthermore, incivility is the antithesis of a psychologically safe working environment, creating a climate of fear where team members may avoid challenging peers or asking for help when required, all of which compromises patient safety.

Civility Saves Lives

Incivility is a patient safety issue. Research has demonstrated that when staff members are incivil, rude, unkind, hostile, this has a significant impact on colleagues who are on the receiving end of their behaviour. This increases the likelihood of human error causing harm to patients.

Uncivil behaviour causes a 61% reduction in cognitive ability in recipients

In addition, there are other impacts on staff:

- 80% lose time worrying about the rudeness;
- 78% reduce their commitment to work;
- 63% lose time avoiding the offender;
- 48% reduce their time at work;
- 38% reduce the quality of their work;
- 25% take it out on others, including service users;
- 12% leave their job.

The Civility Saves Lives campaign aims to raise awareness and encourage civility in the workplace in order to improve patient safety.

CIVILITY SAVES LIVES

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Given the very real and serious risks to patient safety, team functioning and staff wellbeing, it is important that incivility is tackled and harmful behaviour eradicated.

Case Study: GMC and NMC Joint Workshops on Professional Behaviours & Patient Safety

Background
The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) recognise that there is an established body of evidence demonstrating the harmful impact of unprofessional behaviours, including bullying and undermining, on working environments, staff morale and patient safety. There is also evidence that highlights the financial implications of accepting such cultures.

Objective
To help doctors, nurses, midwives and employers improve patient safety through early intervention training that promotes professional behaviours and develops individual's skills and confidence in challenging unprofessional behaviours.

Workshops
GMC and NMC guidance states that Health and Social Care professionals have a responsibility to challenge unprofessional behaviour of colleagues, but we know they find this difficult in practice. GMC and NMC have developed a three-hour workshop to support Health and Social Care professionals to:

1. Define and identify unprofessional behaviours in practice, and reflect on their own behaviours and responsibilities;
2. Understand the harmful impact of unprofessional behaviours on patient safety;
3. Develop individual and practical skills to challenge unprofessional behaviours in the workplace.

GMC and NMC recognise that educating and upskilling groups of Health and Social Care professionals is just one part of the solution for achieving culture change. To have significant and sustained impact, we also need to collaborate with organisations to share good practice and create the optimum environment for positive professional behaviours to thrive.

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Eradicating Harmful Behaviour

The first step to eradicating harmful behaviour is recognising it. Some harmful behaviours are overt, such as bullying and harassment, and are intended to undermine confidence, offend, intimidate, or cause emotional or physical harm.

Examples of Harmful Behaviour:

- Physical or verbal abuse;
- Constant criticism;
- Humiliation;
- Allocation of unfair workload;
- Spreading lies or malicious gossip;
- Exclusion from meetings or events;
- Sexual Harassment;
- Other forms of Harassment, including behaviours motivated by racist, misogynistic, sectarian, homophobic or transphobic attitudes.

Other behaviours are covert and insidious, yet just as damaging. The following 'Red Flag' behaviours are explicitly stated with the intention of empowering others to identify them and raise concerns when they see them, acknowledging that it is not always safe for people to directly 'call out' the behaviour of individuals, who may pose a danger to others.

Red Flag Behaviours of Individuals in the workplace

- Excessive self-interest – putting one's own needs (e.g. for status, admiration, attention etc.) before the wellbeing of colleagues or patients;
- Lack of empathy for the suffering of others;
- Controlling others by using position of power, fear, obligation or guilt;
- Manipulation techniques, such as:
  - 'Playing the victim' to gain sympathy or support;
  - Love-bombing, excessive praise or flattery;
  - Distorting or omitting the truth to get someone to agree to do something;
  - Gas-lighting – denying or distorting reality with the intention of undermining someone's confidence in their own perception or memory;
- Pitting people against each other, or 'divide and conquer', with the intention of maintaining power and control;
- Withholding information to maintain power and control, avoid scrutiny, or with the deliberate intention of affecting a staff member's performance;
- Isolating someone from their support network.

Advice for staff on how to deal with Red Flag Behaviours from co-workers

1. Avoid unnecessary interaction;
2. Stay neutral and professional at all times;
3. Keep firm boundaries;
4. Maintain good relationships with trusted co-workers;
5. Make contemporaneous documentation of events;
6. Speak with and gain support from a Trade Union representative;
7. Raise a concern with your line manager (where appropriate) or Speak Up / Raising Concerns Champion;[xiii]
8. Seek support for your mental health and wellbeing.

Remember: you are not responsible for the behaviour of others; you can only control how you respond (i.e. staying calm, documenting events, seeking advice, raising concerns)

Individuals who display such behaviours can be exceptionally challenging for managers and HR to deal with - in part because some behaviours may arise from fixed personality traits which can be difficult to modify, and also because individuals may not respond well to being challenged or held to account. This should not deter staff from speaking up and is for senior managers and Human Resources to manage.

Red Flag Behaviours in response to being challenged

- Expression of anger or annoyance at being challenged;
- Refusal to accept responsibility or accepting minimal responsibility for one's actions;
- Blaming others or external factors (i.e. work pressures) for their behaviour
- Lack of empathy for those impacted by their behaviour;
- Discrediting victims or witnesses by attacking someone's character or credibility;
- Denial or distortion of events, attacking the victim's character, and making counter-allegations positioning themselves as the 'real' victim (Reversal of Victim and Offender roles);
- Threatening to use HR processes, regulatory referral processes, or legal action to deter scrutiny or avoid accountability.

Tailored training, resources and support are required for Senior Leaders, Line Managers and HR employees when dealing with these complex behaviours.

Given the cost, both human and financial to the health service, from impact on patient safety, staff wellbeing, sickness absence, staff retention, and also reputational risk to HSC services and organisations, it is exceptionally important Managers and HR are not deterred from acting against employees who display harmful behaviour.

[xiii] Speak Up / Raising Concerns Champions are recognised as Good Practice by NI Audit Office - Raising Concerns – Good Practice Guide (NIAO, 2014). RQIA Review of Whistleblowing Arrangements (2016) recommended that each HSC Trust Board appoint a non-executive director for oversight of Raising Concerns.

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‘Leaders and managers should always do the right thing to protect patients and staff from harm’

Ultimately, individuals are accountable for their behaviour. Accountability for harmful and abusive behaviour, includes disciplinary processes, with the possibility of dismissal and, where applicable, referral to professional regulators.

HSC Trust Boards have a ‘duty of care’ to staff and a ‘duty of quality’ to patients – these are statutory duties. Where harmful behaviours are identified, HSC Trust Boards in accordance with their statutory duty should act to ‘do the right thing’ to ensure that patient safety and staff safety is protected.

‘There is no place for harmful or abusive behaviour within HSC’

Violence and Aggression within HSC

Unfortunately, as service pressures have increased, HSC staff have borne the brunt of public frustration, which at times can escalate into violent, aggressive and threatening behaviour. Threatening behaviour can include bullying, intimidation, harassment, inappropriate use of social media, such as filming staff, and threatening staff with weapons.

There is a need for increased public understanding that service pressures are beyond the control of front-line staff, and that abusive or threatening behaviour towards HSC staff does not help the situation and only serves to makes care less safe for patients.

DoH has produced a Framework to tackle ‘Violence and Aggression in the Workplace’.[28] It highlights that service users and relatives may be anxious and worried and it is important for HSC staff to be aware of the potential for this anxiety to escalate into aggressive behaviour. Viewing behaviour through a ‘Trauma Lens’, can improve staff understanding of how unmet needs may impact on patient and family interactions with HSC staff.

Equipping staff to recognise behavioural changes and deploy de-escalation techniques can help prevent incidents of violence and aggression.

It calls for service users, including families and visitors, to understand and respect that there is an expected minimum standard of behaviour towards staff.

‘Any behaviour that puts staff, service users or other persons at risk is not acceptable’. This includes behaviours motivated by prejudice or discrimination against a person on a protected characteristic, for example racism or homophobia.

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Expectation 11: Patients and families are empowered, enabled and informed

11.1 Senior Leaders demonstrate an understanding that understanding that person-centred care fosters safety and trust – and that conversely, harm is caused when empathy, dignity and respect are lacking.

11.2 Staff at all levels consistently demonstrate person-centred approaches to the delivery of care.

11.3 Patients are treated as partners in decision making processes, where there is a focus on 'what matters to you?'

11.4 The principles of Shared Decision Making and Informed Consent are adhered to throughout all aspects of the patient journey.

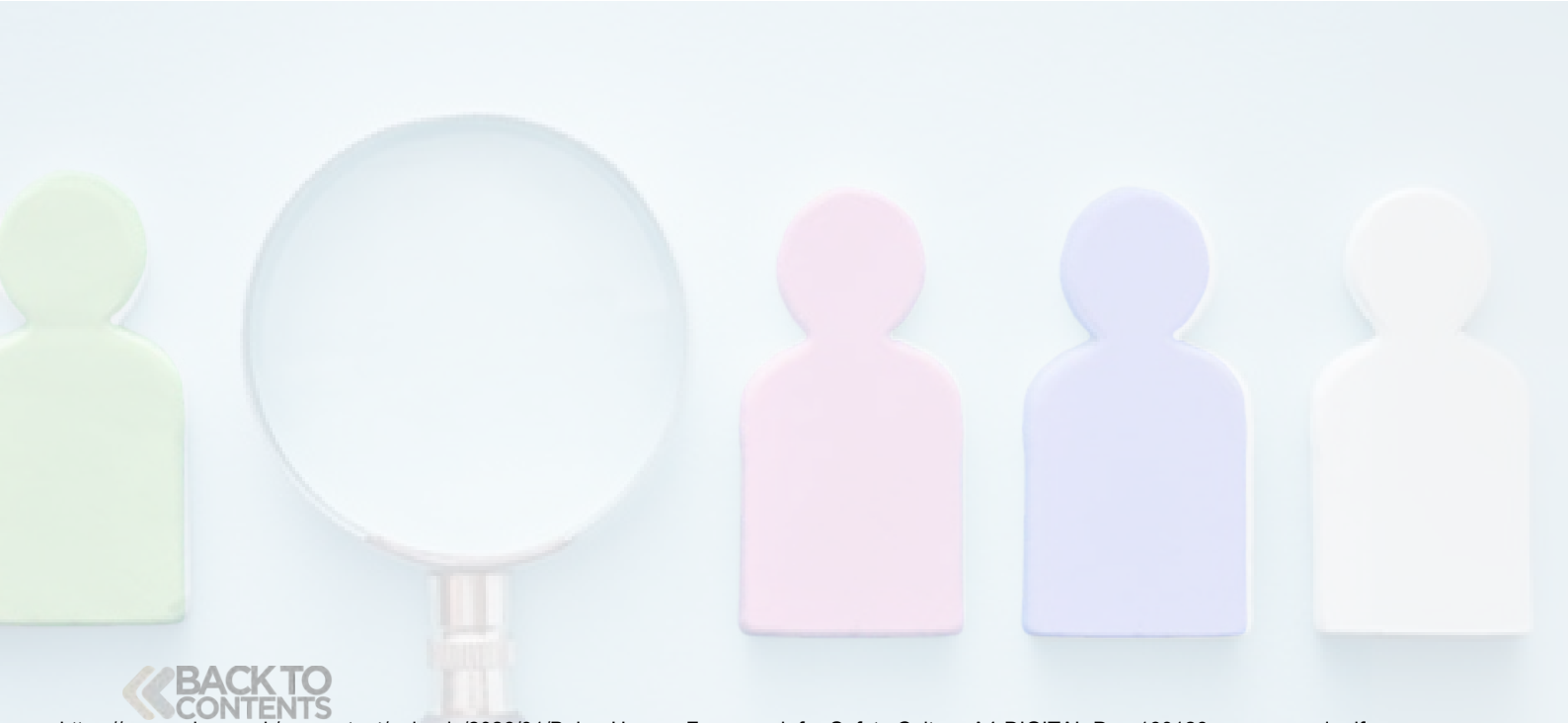
11.5 There is training, resources and support for staff on Person-Centred Care, Shared Decision Making and Informed Consent.

11.6 Range of accessible information materials and patient decision aids to support patients and their families with decisions about their care and treatment, along with access to advocacy support and interpreting services.

11.7 Trauma-informed practice is embedded within pathways of support for patient populations with high incidence of trauma.

11.8 There is effective multi-agency working in providing care to patients and clients with vulnerability factors.

DoH Quality Standard 6.3.2 Service Delivery for Individuals, Carers and Relatives
DoH Quality Standard 8.3 Effective Communication and Information



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2.4 Empowering Patients and Families

Person centred care involves working in partnership with patients to meet their medical, psychological and social needs - shifting the focus from 'What's the matter with you?' to 'What matters to you?'. It can be described as personalised, co-ordinated and enabling, and involves treating patients with dignity, compassion, and respect.[29]

'Person-centred care fosters safety and trust'

Trust and co-operation are maximised when patients are afforded autonomy, provided with full unbiased information on treatment options and regarded as partners in decisions about their care.

Conversely, harm is caused when empathy, dignity and respect are lacking

Empowering patients to be partners in their care creates psychological safety within the therapeutic relationship by counteracting hierarchy and paternalism. Research shows that providing person centred care can have a positive impact not just on patient outcomes and experience but also on staff morale and wellbeing.

Person-centred care does not require additional clinical skills, but rather a shift in mindset. Initiatives such as 'What matters to you?' can help embed a culture of person-centeredness.

> **"What matters to you?"**

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Valid and Informed consent

All patients have a right to be involved in decisions about their care and treatment, if able to do so. Valid consent ensures that patients have mental capacity to make decisions about their care and do so voluntarily, without coercion from others. Informed consent ensures that patients are given full information on benefits, risks and alternative options.

Informed consent has been topical since the 2015 Montgomery Vs Lanarkshire ruling[30,31], a landmark case that stipulated patients should be given information on all material risks. A failure to seek informed consent for treatment has legal and ethical implications and can result in harm to patients.

To avoid these issues, it is important that Health and Social Care professionals adhere to clinical guidelines and professional standards in Shared Decision Making and Informed Consent.

Good practice in Shared Decision Making[32] and Informed Consent

1. Give patients clear, accurate and up to date information on all their options, describing the potential benefits and risks of each, including the option to take no action.
2. Be open, honest and forthcoming about treatment options, their benefits and risks. Tell patients about any risk of serious harm, however unlikely it is to occur.
3. See patients as individuals. Clarify the patient's needs, hopes and expectations. Tailor the discussion to each individual patient, in accordance with what matters to them, and share information in a way that they can understand.
4. Consider using visual or explanatory aids. Make special arrangements for patients who have challenges with communication, understanding or learning.
5. Answer questions openly and honestly, including where there is uncertainty around the diagnosis, the most appropriate treatment, or the likely impact from a particular treatment.

Sharing information with patients and carers

All patients benefit when they are provided with clear and accurate information on their care and treatment. Providing patients with access to lay language clinic and discharge letters can promote better patient engagement, empower people to manage their health and, where appropriate, challenge the quality of care and treatment they are receiving.

Information should be provided to patients and carers in a way that they can understand. Patients may require access to interpreting services or other reasonable adjustments, and these should be facilitated.

Case Study: Supporting adults with learning disability through their cancer pathway using a visual Story Book

Background

Evidence reports that people with a learning disability often have poorer access to services, evidenced by lower screening uptakes and delayed cancer diagnosis. In order to be inclusive and to support people to navigate services, information must be tailored to service user needs.

Therefore, a designated cancer pathway for learning disability was developed to enable reasonable adjustments to ensure patients with a learning disability were afforded the same choices and equity.

The need for supportive literature was identified and this would take the form of a visual aid storybook, detailing what to expect when attending the North West Cancer Centre (NWCC).

This would provide easy to understand information for the service user enabling them to understand, participate and be involved in the decisions about their care.

Development of the Story Book

A collaborative, co-production approach was used incorporating professionals from learning disabilities, cancer services and service users/carers.

Focus groups were held within the Macmillan Support Centre with reasonable adjustments to facilitate service user participation in the co-production process.

The Story Book was launched to coincide with World Cancer day 2025.

Outcomes

The visual storybook enables better engagement with adults with learning disabilities in order to improve access to cancer services, and support people to make decisions about their care.

Alongside the HSC Learning Disability Hospital Passport and cancer for Learning Disability pathways, this ensures a more inclusive and equitable service for this population.

Service users with complex needs or additional vulnerabilities, may benefit from independent advocacy services, trauma-informed approaches, and effective multi-agency working in order to effectively tailor approaches to meet their needs and preferences.

Red Flag Behaviours

1. Paternalistic attitudes towards patients and families
- Failure to listen to patients, carers and families;
- Absence of shared decision making.

2. Lack of empathy and compassion for patients and families
- Failure to provide dignity and respect.

3. Failure to adopt person-centred care
- Blanket 'one size fits all' approaches to patient care;
- Refusal to take patient needs and preferences into account.

4. Inadequate provision of information
- Lack of informed consent;
- Underutilisation of interpreting services.

Expectation 12: Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues

12.1 Senior Leaders role model the behaviours of active listening, understanding, empathising, responding and supporting.

12.2 Senior Leaders promote a narrative that patients and family voices are valuable and should be listened to at all times.

12.3 Staff at all levels demonstrate an understanding that patients and families have a valuable contribution to make in raising concerns about safety of care both during the patient journey and in the aftermath of a poor experience.

12.4 Health and Social Care professionals demonstrate an understanding that being dismissive of patient and family concerns can cause both psychological and physical harm.

12.5 Clinical teams, Health and Social Care professionals, and non-clinical staff promote psychological safety in all interactions with patients and their families.

12.6 Health and Social Care professionals understand their professional responsibilities to respond to requests for second opinion.

12.7 Second opinion requests are viewed as valuable safeguards against patient harm, and are not be viewed as criticism or an indication of individual weakness.

12.8 Managers and Health and Social Care professionals understand that they have a duty to listen, hear and act on safety concerns shared with them by others, understanding that 'you cannot un-know what you know' and that we are all responsible for keeping patients safe.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

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2.5 Listening, Hearing, and Acting

The clinician-patient interaction itself has been demonstrated to confer a therapeutic benefit. When patients and their families are listened to and feel that their concerns are validated and acted upon; this has benefits that go beyond the clinical treatment itself. Not listening to patients or family members, misses an opportunity to enhance trust, allay distress and improve clinical outcomes.

> "When I tried to politely explain that the range for the investigation was wrong, the Consultant walked up and down the floor saying that he was the expert, there was nothing wrong with the range, and I was interrupting him. I wasn't interrupting him as I was barely able to get a word in..."
>
> Expert by experience

Being dismissive of patient and family concerns, risks missing important clinical information from a safety perspective, but can also cause harm to patients as they feel unsupported during a vulnerable period of ill-health and associated psychological stress.

Listening to Families

Families can provide a valuable insight into their loved one's condition; if a patient or their family asks for a second opinion, then this should be facilitated[xiv, 33] – a request for a second opinion should not be perceived as a criticism or weakness by the clinical team providing care. A second opinion can serve as a valuable safeguard against patient harm, or may simply provide reassurance to the patient and their family.

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

Whilst Martha's Rule has not been implemented in NI, the same principles of **'listening, hearing and acting'** should apply.

[xiv] GMC Good Medical Practice (January 2024). States "You must recognise a patient's right to choose whether to accept your advice, and respect their right to seek a second opinion".

Listening, Hearing and Acting on the concerns of other professionals

Professional regulators stipulate that Health and Social Care professionals must work well with colleagues in order to deliver safe, effective care. Part of working well with others involves listening, hearing and acting on immediate patient safety concerns – this includes concerns raised within teams, but also by colleagues from other disciplines and other sectors.

> "The PSNI officers who had spent hours waiting with the patient and talking with him were very concerned about the risk posed by the patient. The [healthcare professional] admitted to talking to them for "less than 30 seconds". He ignored what the PSNI were trying to say; he did not obtain collateral information from the PSNI. This had fatal consequences."
>
> Expert by Experience

'Patient safety is paramount'. When a colleague raises a concern, regardless of how busy we are, or who the colleague is, be it a junior member of the team or a staff member from another team, service or sector, **'any concern raised should be treated as vital information'** and must be appropriately considered in order to safeguard patients from harm. **'We all play an important role in keeping patients safe'**.

Listening, Hearing and Acting enhanced by mutual trust and respect

Supporting safety within and across the HSC system necessitates both trust and respect.

Where HSC leaders and managers trust and respect their staff, staff, in turn, trust and respect leaders and managers.

Health and Social Care professionals must behave in ways that are trustworthy and respectful towards patients, carers and families, who are likely to feel anxious and vulnerable during their care episode. Such anxieties and vulnerabilities can be exacerbated in situations where HSC system pressures lead to suboptimal delivery of care and treatment. In these circumstances, staff often bear the brunt of patient and public frustration.

There is a need for greater awareness amongst the public around HSC system pressures. Open and honest conversation can serve to enhance public understanding of the pressures HSC staff face and serve to ensure that respect is two-way.

In empowering patients, families and staff to raise concerns about quality and safety, there is an onus to support people to do so in ways that are both effective and respectful, just as there is a duty on the HSC system to **'Listen, Hear and Act'**.

https://www.rqia.org.uk/wp-content/uploads/2026/01/Being-Human-Framework-for-Safety-Culture-A4-DIGITAL-Doc-160126-compressed.pdf

Red Flag Behaviours

1. **Dismissive of concerns**
   - Being dismissive of patient and family concerns;
   - Failure to listen to the concerns of colleagues;
   - Attempts to discredit a patient, family or colleague's character in order to justify not listening to their concerns.

2. **Failure to allow or accept other professional opinions**
   - Rejecting requests for a second opinion;
   - Dismissing the opinion of other professionals.

3. **Working in isolation**
   - Working in isolation from colleagues.

4. **Failure to participate in appraisal and governance**
   - Failure to respectfully and constructively participate in appraisal and governance activities, such as clinical audit, quality improvement and Mortality and Morbidity meetings.

Expectation 13: All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions

13.1 Just culture principles of fairness, openness and learning are embedded within systems, policies, procedures and approaches to managing incidents, concerns and complaints.

13.2 Senior Leaders showcase examples of just and restorative culture leading to: openness, healing for individuals and teams, improvements in patient safety.

13.3 Training for Leaders and managers on patient safety, human factors, and the application of just and restorative approaches and principles.

13.4 Incident review panels are skilled and trained in empathetic, compassionate and restorative approaches to approaches to engaging with those involved in safety incidents.

13.5 When harm occurs, all those impacted by the harm, which may include staff, patients, victims and families, experience empathy, compassion and support, along with thoughtful consideration of their needs; including the need for professional or clinical support.

13.6 There is access to counselling and clinical psychology for patients, families and staff impacted by safety incidents.

13.7 Staff feel confident reporting incidents/errors, engaging in incident reviews, and do not fear blame or punitive action.

13.8 Staff involved in patient safety incidents and complaints are supported to engage candidly in review processes for the purposes of system learning and improvement.

13.9 Senior Leaders demonstrate an understanding that accountability is collective and that ultimate accountability for quality and safety sits with the HSC Trust Board.

13.10 Leaders and managers demonstrate an understanding that most of the time when things go wrong, it is because of complex, imperfect systems and challenging working conditions.

13.11 Staff at all levels demonstrate an understanding that 'anyone can make a mistake' – and when mistakes happen, we must all learn from them, and use the learning to improve the system.

13.12 Senior Leaders demonstrate an understanding that there is clear distinction between intentionally harmful, negligent or deceitful behaviour - and human error.

13.13 Leaders and managers demonstrate an understanding that punishing people for mistakes does not achieve improvements in patient safety and only contributes to fear, secrecy, and further harm within the HSC system.

13.14 Blame and punishment for individuals is rare, and reserved for deliberate negligence, wrongdoing, 'cover-up' and concealment.

DoH Quality Standard 5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

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2.6 Just and Restorative Culture

Just and restorative culture refers to the collective actions and behaviours of individuals within an organisation in response to safety incidents.

It is about treating people fairly, but also responding compassionately to meet the needs of individuals and restore confidence and trust in the HSC system, with an understanding that **'ultimate accountability for patient safety sits with the HSC Trust Board'**.

'Just culture is critical for harm prevention'. A just culture is necessary for open culture; and an open culture is necessary for learning and improvement.

Unless there is a culture of openness and confidence in staff that they will be fairly treated and that there will not be undue punitive action, staff will be too afraid to make disclosures during incident investigations.

This fear of blame not only adversely affects staff wellbeing, it hampers system learning, hinders improvement and impacts negatively on patient safety.

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes"

The 'Father of Patient Safety' Dr Lucian Leape, Harvard University

In a Just Culture, Leaders understand that there is clear distinction between intentionally harmful, negligent or deceitful behaviour - and human error.

We are all human and **'anyone can make a mistake'** – when mistakes happen, we must all learn from them, and use the learning to improve the system. Most often when things go wrong it is because of complex imperfect systems and challenging working conditions.

Leaders understand that **'blaming and punishing people for mistakes does not achieve improvements in patient safety'** and only contributes to fear, secrecy, and further harm within the HSC system.

Therefore, when harm occurs, it is viewed through a lens of system learning and improvement, individuals are supported to learn and improve, and to contribute constructively to patient safety.

In the unusual event that there has been deliberate harm or negligence, this is dealt with separately to the learning process.

Tool such as NHS 'Being Fair'[34] can be used to assist employers with making decisions when negligence or Fitness to Practice Concerns arise. However, it should be noted that such algorithms or tools are not for routine use, understanding that the vast majority of quality and safety incidents occur, not because of the sole actions of an individual, but because of an interplay of system factors, human factors and honest mistakes. Remembering that **'blaming and punishing people for mistakes does not improve patient safety'**.

Good practice in reviewing patient safety incidents

A good Patient Safety Incident Review will:

- Compassionately support all those impacted, consider their needs and appropriately involve them in the review process;
- Adopt an empathetic and sensitive person-centred approach, creating psychological safety for openness and candour amongst those engaging with the review panel;
- Aim to establish the facts of what happened, and why, providing answers to all those affected;[xv]
- Derive Learning and inform timely improvements in Patient Safety.

By its nature, a Patient Safety Incident Review is not a punitive or evasive process. However, poor application of an incident review process can mean it may be perceived as punitive by staff and as evasive, lacking in candour, compassion and sensitivity for those who have been harmed.

The following case sets out two Serious Adverse Incident reviews, both conducted for the same safety incident described below. The First Review is considered as an example of poor practice, and the second Review represents good practice.

Case Study

My parents-in-law were violently killed by a mental health patient. In the five days preceding the killing, the patient sought help four times, at three different hospitals, in two different Trusts. On two of the occasions there was significant interaction with the PSNI. The patient presented with worsening paranoia, delusional-thinking and self-harm. At no time did he receive the help he so desperately needed. At the inquest into the deaths of the victims, the coroner found the deaths to be "entirely preventable".

Expert by Experience

[xv] Patients, victims, families and HSC staff

	First Review	Second Review
Adhering to Procedure	The SAI Procedure for investigating 'mental health homicide' was not followed correctly.	The SAI procedure was followed and the panel was provided with training on the SAI procedure.
Level of SAI Review	The Level of Review was inappropriately assigned to Level 2. As such, the SAI did not have a fully independent panel.	The Level of Review was appropriately assigned to Level 3. The SAI had a fully independent panel.
Drafting a Terms of Reference	The Terms of Reference did not include mandatory requirements and were not sufficiently robust.	The Terms of Reference were drafted in compliance with the procedure and with involvement of the victims' family.
Involving families	The family of the victims was excluded from involvement in the SAI review. When the family asked to be involved, the request was rejected and the family were hurt and re-traumatised.	Families were sensitively involved from the outset. They were given regular updates. Their questions were answered and they were provided with draft copies of the report for comments, which were subsequently taken into consideration.
Gathering and analysing evidence	Only six people were interviewed as part of the process; inappropriate given the number of organisations and agencies involved in the incident. Information provided by interviewees was accepted at face value with no attempt to verify the information. Information provided to the panel was subsequently demonstrated to be false. Analysis of information was suboptimal. A factual account of events was not achieved.	Over sixty people were interviewed, including PSNI Officers. Information was triangulated in order to establish facts, to understand what happened, and why. The Review Panel met their commitment to: Evaluate the standard of care delivered by all agencies involved in the SAI objectively.
Drawing Conclusions	The review concluded "there were no factors in the health & social care services and interventions delivered or omitted to "xxx" that caused or influenced the suspected homicides"	The review identified two factors that were "*causal*" in the deaths and twenty-two factors that were "*contributory*".
Preventing similar harm occurring in the future	There was a missed opportunity to identify learning that could have prevented further deaths within the region.	Consequently, the SAI Review made a total of eleven recommendations all of which had the potential to help prevent further incidents and save life.

"The patient safety incident review process is the vehicle by which the ability to learn and implement change to prevent harm, and most importantly save life, should be efficiently and effectively demonstrated with full honesty and openness.

It is not a vehicle for the protection of individual and organisational reputations. If an individual or organisation acts correctly, honestly, and openly, their reputations will look after themselves."

Expert by experience

https://www.rqia.org.uk/wp-content/uploads/2026/01/Being-Human-Framework-for-Safety-Culture-A4-DIGITAL-Doc-160126-compressed.pdf

Red Flag Behaviours

1. **Blame culture**
   - Incidents are seen as due to staff errors;
   - Patients and families are blamed for safety incidents;
   - Punitive action against staff.
2. **Lack of support for those impacted by safety incidents**
3. **Lack of candour**
4. **Lack of learning and improvement**
   - Learning derived from safety incidents is limited;
   - Failure to implement improvements following safety incidents.

Expectation 14: Openness and candour is promoted and supported at all levels in the organisation

14.1 There is an Organisational vision and strategy for Patient and Staff Safety and Wellbeing that is explicit about the requirement for just, open and learning culture.

14.2 There is HSC Trust Board-level commitment to a just culture of fairness, openness and learning.

14.3 Senior Leaders understand that they are accountable for creating fair, open and supportive cultures where there is compassion for those who make mistakes and where speaking up is highly valued and encouraged.

14.4 Floor to Board, there is routine openness about patient safety and staff wellbeing metrics enabling collective accountability and system improvement.

14.5 From 'Floor to Board', there is open, honest and transparent communication; supported by effective mechanisms for sharing information.

14.6 Senior Leaders promote a narrative that 'there is protection in the truth' and share examples of how openness and candidness has been responded to with compassion, support and has led to improvements.

14.7 Senior Leaders consistently demonstrate that when people are open and honest, and willing to learn, are not blamed or punished for mistakes.

14.8 Staff at all levels demonstrate an understanding that candour promotes healing, recovery and restoration of trust for those who have experienced healthcare-related harm.

14.9 Managers and Health and Social Care professionals are supported to engage early with patients, victims and families who have experienced healthcare-related harm, in order to provide a meaningful apology; acknowledgement of harm; and any information that is known, with an open acknowledgement of what is unknown or uncertain, and a caveat that a formal investigation may find different facts.

14.10 Whilst information on formal procedures is provided, it should not be used to delay apology, acknowledgement and, if possible, answers.

DoH Quality Standard 5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

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2.7 Open Culture

‘A just culture is necessary for open culture; and an open culture is necessary for learning and improvement.’

HSC Trusts are responsible for fostering a culture of openness; a pre-requisite to this is just culture, and a clear sequitur is a learning and improvement culture.

People will not be open, unless they feel psychologically safe, and they will not be able to learn and improve unless there is both psychological safety and a culture of openness.

McBride (2024) identifies three key aspects of cultural openness:

1. Routine Cultural openness;
2. Openness focused on constant learning;
3. Openness when things go wrong.

Candour

Candour is about ‘being open’ and honest with patients and families when care has gone wrong. Candour facilitates psychological healing, physical recovery, and may serve to restore trust in the health and social care system.

Good Practice Example

I’ve had a long-term health condition for many years that requires management with specialist drugs. A GP once prescribed an antibiotic which caused an interaction with one of them. I became very unwell.

When I saw a doctor at the specialist unit, I said it was my fault, as I thought, in a way, I was partly to blame. I did not want the GP blamed. The doctor replied, ‘no it’s our fault’. There was complete transparency. There was no blame [of the GP].

Later I was also told by a doctor at the unit that because of what had happened to me a letter had been circulated to all their patients’ GPs with a list of medications that reacted with the specialist drugs they used.

As such, there was transparency, learning, action taken to improve patient safety, and no blame.

Lived Experience

https://www.rqia.org.uk/wp-content/uploads/2026/01/Being-Human-Framework-for-Safety-Culture-A4-DIGITAL-Doc-160126-compressed.pdf

When harm occurs, it is important that those impacted by the harm experience compassionate, restorative behaviours of listening, understanding, informing, and a commitment to making things right; actions taken should include an acknowledgement that harm has occurred and a meaningful apology.

'There is power in an apology – it is not an admission of guilt but rather an opportunity to heal and repair'

"I sat in a meeting last week where a client asked for an apology for what had happened and no-one spoke, the client was in tears. Still no-one spoke until I said 'an apology is literally in the guidelines and wasn't an admission of guilt, just an acknowledgement'. Still no-one spoke, so we left…"

Patient Advocate

What good looks like:
Being open and honest when care goes wrong

Leaders, managers and all staff are supported to understand that there is:

- Protection in the truth;
- Power in an apology;
- Healing in acknowledgement.

… and 'it is OK to not have all the answers', as long as you are open and honest that you don't!

Most people, when harm has occurred, need to know that it will not happen to anyone else. Those impacted should be offered an explanation of next steps to review the incident so that learning and improvement can be derived.

"My experience was regarded as a 'never event' and the senior doctor on call that night said it would be investigated however no action was taken. The lead consultant detailed a vague and inaccurate report of events… There was zero openness and honesty around my care, nobody wanted to identify or take responsibility for what happened or indeed learn."

Expert by Experience

Importantly, be it in the immediate aftermath, or during the course of an incident review, patients and families must be facilitated to get answers and to be told the truth.

Candour promotes healing, recovery and restoration of trust for those who have experienced healthcare-related harm. Conversely, a failure to be open and honest with patients and families compounds harm and reduces the opportunity for learning and improvement.

> **There's only one little word that will heal, and that's the truth. I can cope with the truth, but I cannot cope with not knowing the truth... I can cope with what I know is the truth, but not with what I don't know. Cover up only compounds grief when the truth finally comes out.**
>
> **Norma Sparkes, Mother of Stephen Sparkes[xvi]**

Professional regulators stipulate that Health and Social Care professionals have a duty to be open and honest when care goes wrong.

However, organisational cultures can make it difficult for Health and Social Care professionals to 'be open' or 'speak up'. In some cases, there can be a realistic threat to people's jobs, careers and professional reputations, creating a climate of fear.

This raises important ethical questions about where the balance of accountability should lie – on individual Health and Social Care professionals or on organisations to support them by making it safe to 'be open' and 'speak up' without fear of being isolated, scapegoated or experience further retribution.

When people experience intense fear and anxiety, they may shut down, deflect blame or tell investigators what they think they want to hear; at its worst fear can cause people to conceal or 'cover up' what really happened; meaning the truth needs to be "dragged out of them" by Public Inquiries.[xvii]

In order to achieve a culture of openness and honesty, Health and Social Care professionals require confidence that 'being open' will not result in punitive action. It needs to be **'a lived reality that there is protection in the truth'**. Crucially, that people who are open and honest, and willing to learn, are not punished for mistakes. This requires compassionate leadership within the HSC system and an understanding that HSC Trusts are accountable for driving just, open and learning cultures.

[xvi] Norma Sparkes' son, Stephen Sparkes, is a deceased patient of Michael Watt. Since Stephen's death, Norma has advocated for improvements in Patient Safety within the Health and Social Care System in NI.

[xvii] Quote from Justice O'Hara following publication of IHRD Inquiry (2018). Children's hospital deaths were avoidable - BBC News

Red Flag Behaviours

1. **Staff are discouraged from or punished for candour, i.e.:**
   - instructed not to submit incident reports;
   - criticised or punished for submitting incident reports;
   - instructed not to be open and honest;
   - punished for being open and honest.

2. **Policies and procedures are misused, i.e.:**
   - to avoid openness and transparency;
   - to avoid accountability;
   - as weapon for victimisation.

3. **Attempts to mislead investigators, regulators, coroner's, independent reviews or inquiries**

4. **Resistance to external scrutiny**

Domain 2: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Health and Social Care (Reform) Act 2009;
- Human Rights Act 1998;
- Disability Discrimination Act;
- Health and Safety at Work (NI) Order 1978;
- DoH Collective Leadership Strategy;
- NICE Quality Standards QS15. Patient Experience in adult NHS Services;
- NICE Guidance NG197. Shared Decision Making;
- NIPSO HSC Model Complaints Handling Procedure;
- Social Care Institute for Excellence - Dignity in Care, Freedom to choose;
- NHS England Framework for involving patients in patient safety;
- NICE Guidance NG13. Workplace health: management practices;
- NICE Guidance NG212. Mental Wellbeing at Work;
- NHS England. Health and Wellbeing Framework;
- NHS England. Civility and Respect;
- NHS resolution- Just and Learning Culture Charter.

Cultural Domain 3: Curiosity and Constructive Challenge

Domains	Themes	Expectations
Curiosity and Constructive Challenge	**Addressing fear and defensiveness**	Fear is addressed by acknowledging the impact of past trauma and by challenging unhelpful narratives and beliefs.
		Early engagement is embraced as an opportunity for early resolution and system learning.
	Making it safe for staff to speak up	Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system.
		Speaking up is highly valued and encouraged and results in action to improve patient safety.
	Being curious to learn and improve	Time and space for reflection is created at all levels in the organisation.
		Learning is Shared in a Meaningful Way that has Impact.

Expectation 15: Fear is addressed by acknowledging the impact of past trauma and by changing unhelpful narratives and beliefs

15.1 Senior Leaders allay fear within the HSC system by seeking to shift away from mindsets that promote defensiveness and a lack of openness, which are counter to learning, and towards healthier mindsets of acceptance, resilience, and an unwavering commitment to openness, learning and improvement.

15.2 Senior Leaders make a concerted effort to change unhelpful narratives and beliefs around processes that staff are fearful of and find stressful.
[See Good Practice on Page 82]

15.3 Senior Leaders and all staff demonstrate an understanding that HSC Trust processes should not be used as a barrier to human interaction and engagement, and that all staff involved in a HSC Trust process should be offered meaningful support.

15.4 Managers who utilise HSC Trust policies and procedures demonstrate a clear understanding of the spirit within which the procedure was drafted and are accountable for using policies and procedures fairly and proportionately.

15.5 HSC Trust Policies and procedures are applied fairly in accordance with HSC values, and are not be used to avoid openness, transparency and accountability, or as weapon for victimisation.

15.6 HSC Trust Policies and procedures are only initiated when necessary (i.e. policy thresholds are met), understanding that processes can be experienced as stressful, bureaucratic, and lengthy.

15.7 There are assurance mechanisms in place to ensure that HSC Trust policies and procedures, and their application are fair, and free from bias and discrimination.

15.8 Feedback is proactively gathered on the experiences of patients and staff who have engaged in incident, complaints or raising concerns procedures; information gathered is used to drive improvements in the application of policies and support available for those impacted.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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3.1 Addressing Fear and Defensiveness within the Health and Social Care System

The legacy of 'The Troubles' and political instability on HSC structures, HSC workforce and NI population has undoubtedly had an impact on culture within HSC.

Direct rule, socio-economic inequalities and intergenerational trauma stemming from sustained periods of violence is likely to have contributed to engrained cultural elements, such as hierarchical mindsets, blame culture, mistrust of authority, and a lack of openness and transparency.

There is also an impact on HSC staff previously involved in investigations, litigation and inquiries[xvii], whereby the trauma of investigation processes and a perception of blame, may compound pre-existing psychological adversity. The repercussions of these traumatic experiences can be significant and longstanding, affecting entire clinical teams and services.

For this reason, HSC staff involved in public inquiries and coroner investigations, which involve intense scrutiny, accompanied by media coverage, should be offered enhanced support, such as access to clinical psychology and the adoption of trauma-informed approaches by leaders and managers.

It is important to acknowledge that there is also fear within the HSC system amongst staff who themselves have had no previous experience of investigative processes; this occurs because fear is engrained within the culture, perpetuated by unhelpful narratives and beliefs within organisations, causing an unnecessary level of anxiety and defensiveness, counter to openness and learning - 'Fear hinders learning and hampers improvement'.

> "As a young student, during my nursing training I remember being told **'watch out for the big wigs!'** and that's something that has stayed with me for so long... there can be a real fear of making mistakes and a lack of psychological safety within the HSC system."
>
> Lived Experience of a clinician

It is important that this cultural fear is addressed by Senior Leaders within HSC organisations in order to promote mindsets consistent with openness, learning and improvement.

[xvii] For e.g.: Serious Adverse Incident Reviews, Coroner processes, Litigation, Public Inquiries, Regulatory Review and Investigations

15.2 What good looks like: Allaying fear within HSC System

Staff may fear processes such as internal HSC Trust processes, whistleblowing, complaints, safety incident reviews, litigation, coroner inquests, inquiries, investigations, regulation and associated media coverage.

Efforts to allay fear of such processes involves:

- demystifying processes;
- training, guidance and resources for staff;
- providing reliable, unbiased and balanced information on processes, including the range of possible outcomes and support available;
- enhanced support for staff, including access to counselling and clinical psychology;
- providing case examples where staff have been supported through processes.

The task for HSC organisations and regulators is to embed just culture principles within the systems and processes for learning from harm and support their staff in a trauma-informed way that lessens fear and anxiety, creates psychological safety to encourage open, candid disclosures, maximising healing for those impacted, and learning and improvement for the HSC system.

What good looks like: Preventing Defensiveness

Defensiveness impacts on the ability of individuals, teams and organisations to learn. It arises from a fear of repercussions amongst staff, when care goes wrong.

Effective leaders adopt a number of strategies in order to promote mindsets that prevent defensiveness and create receptiveness to learning, in order to improve patient safety. These may include a concerted effort to:

1. Foster psychological safety, just and restorative culture – (i.e. if I make a mistake, I will be treated with compassion, and supported to learn and improve);
2. Promote curiosity in everyday practice – (i.e. things did not go well today, I wonder how we can do better for patients and for staff);
3. Encourage reflection – (i.e. I am going to take time to intentionally reflect on my practice, the culture within our team, and how we impact on the patients we provide care to);
4. Promote a 'growth mindset' - (i.e. Mistakes are an opportunity for personal learning and growth).

Alongside changing mindsets, it needs evidenced to staff that they will indeed be treated fairly and supported, should they become involved in processes, including HSC Trust processes, which should always be applied in a consistent and fair way, without bias or discrimination.

Equally, external agencies, including both professional and system regulators, must demonstrate that they will act fairly and proportionately, when concerns with quality, safety and clinical practice are identified.

Expectation 16: Early engagement is embraced as an opportunity for early resolution and system learning

16.1 Early engagement in response to concerns/complaints from patients and families is embedded within the organisation for the purpose of listening to concerns/complaints, understanding and recording any questions patients/families want answered, offering a meaningful apology and acknowledgement of harm/poor experiences, identifying learning and driving improvement.

16.2 Leaders and managers are equipped and supported to seek early resolution to concerns, negative feedback and complaints.

16.3 Training and resources for managers and Health and Social Care professionals to support early engagement with patients and families who have concerns and complaints.

16.4 There are mechanisms to derive learning from the early resolution of complaints; learning is used to drive improvements in systems for safety and care delivery.

16.5 Leaders and managers showcase examples of early engagement leading to early resolution and system improvement.

16.6 Senior Leaders role model compassion, humility, and a desire to learn and learn and improve.

16.7 Leaders, managers and all staff are supported to understand that there is:

- protection in the truth;
- power in an apology;
- healing in acknowledgement;

And 'it is OK to not have all the answers', as long as you are open and honest that you don't.

DoH Quality Standard 8.3 Effective Communication and Information

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3.2 Early Engagement and Resolution

> "The [HSC system] cannot seem to learn that it is better to acknowledge mistakes and other problems early... rather than continue pouring petrol on the fire.... Compounding more harm on compounded harm."
>
> Patient Expert by Experience

When patients and families have had a poor experience of healthcare, including when care goes wrong, they might have unresolved care issues that need addressed and will often want to know that what happened, will not happen to anyone else.

When someone raises a concern about their care and treatment, with the motivations of rectifying issues in their own care and / or with the motivation of improving patient safety for others, they are often directed into a formal complaints process.

> "Nobody attempted to raise what happened internally. After I raised it as complaint, it sat for a year before being raised to a SAI, which took another 16 months to investigate....."
>
> Patient Expert by Experience

The difficulty with complaints processes is that patients and families can experience them as:

- Unnecessarily lengthy;
- Bureaucratic;
- Lacking in human connection;
- And importantly, failing to address patient safety issues – either for the patient as an individual (in the case of unresolved care issues) or for the wider patient population.

It should be noted that following the Independent Neurology Inquiry, improvements are being made to complaints handling within the region. NIPSO is leading reform of the complaints standards[xix], and individual HSC Trusts are implementing mechanisms to ensure that complaints are viewed through a patient safety lens. These changes are anticipated to make substantial improvements and it is important that these are capitalised upon, in order to drive a cultural shift towards early engagement and resolution of concerns.

When people are engaged early there are benefits that go beyond what a complaints process can deliver. When an apology and acknowledgement of harm is delivered in a meaningful way it can promote healing and recovery, and restore trust in the HSC system. It also provides an early opportunity to understand and record any questions that patients and families may have, to provide answers (if available) and to derive early learning and improvement for the system.

[xix] NIPSO are leading on a transforming complaints standards in the Health and Social Care (HSC) sector. The HSC Model Complaints Handling Procedure (MCHP) sets new Standards for how the sector in Northern Ireland manages complaints.

Expectation 17: Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system

17.1 Senior Leaders foster a culture of curiosity and embrace constructive challenge by role modelling positive behaviours and creating psychological safety for staff at all levels to be curious, to constructively challenge, and to drive learning and improvement.

17.2 Senior Leaders role model compassion, humility, and a desire to learn and learn and improve.

17.3 Leaders and managers welcome and respond graciously to constructive criticism, expressing gratitude, acknowledgement and a commitment to ensuring issues with patient safety or staff wellbeing are addressed.

17.4 Staff at all levels are empowered and supported to receive and provide constructive feedback as a means to learning and improving.

17.5 Senior Leaders role model and demonstrate the humility to receive constructive feedback in the manner that it is intended and use this to drive improvements.

17.6 Senior Leaders deliver feedback in a constructive and professional manner. All staff are supported to receive feedback in the spirit within which it is intended in order to drive learning and improvement.

17.7 At all levels, staff feel safe and supported to constructively challenge the status quo.

17.8 Senior leaders encourage staff at all levels to continually strive to find ways to understand if things can be done better for the benefit of patients, families and staff.

17.9 HSC Trust Boards and Senior Leaders seek out learning from other organisations, reviews and inquiries in order to drive internal system improvements.

17.10 HSC Trust Boards and Senior Leaders demonstrate courage to welcome external scrutiny and there is routine openness and transparency around the learning derived and improvement plans.

17.11 HSC Trust Boards recognise the value in external scrutiny, and when required, actively seek support from external bodies. i.e. DoH, Commissioners, Regulators, Royal College Invited Service Review programmes, in the interest of receiving external assurance and support to improve Patient and Staff Safety and Wellbeing.

DoH Quality Standard 8.3 Effective Communication and Information

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3.3 Embracing Constructive Challenge

Constructive challenge is essential in an open, learning and improving system.

Challenge, by its nature, can feel difficult. For HSC staff from underrepresented groups, it can feel even more difficult to provide challenge. This can be due to non-inclusive working environments; also in some countries outside of UK, it can be considered culturally disrespectful to challenge authority.[xx] For these reasons, HSC staff from diverse backgrounds may require additional support to feel empowered to challenge.

Challenge can feel uncomfortable for not just for those providing it but also for those receiving it. If the intention behind the challenge is not mutually understood or if it is delivered in a way that is harsh or insensitive it can evoke feelings of embarrassment and humiliation, and impact negatively on team relationships – all of which are counter to learning and improvement.

This is why **'challenge must always be constructive'**.

In order to embrace constructive challenge as an effective means to driving improvements in patient safety, the following actions need to be taken:

1. Create a collective understanding of the purpose of challenge;
2. Role model positive behaviours in providing and receiving challenge – curiosity, humility, and a desire to learn and improve;
3. Ensure that when challenge is delivered it is respectful and constructive; providing training and resources to support staff;
4. Support people to receive challenge in the way that it is intended – to remove the ego and understand **'it is not about me – it's about doing the best for patients'**;
5. Normalise constructive challenge – by building it into everyday business.

Skills in 'constructive challenge' can be practiced through the delivery of 'constructive feedback' when supervising or training students and junior colleagues.

Constructive feedback in itself is a skill, underpinned by a desire to support training and professional development, without inadvertently undermining or demoralising those receiving the feedback. The intention is to develop the next generation of capable and competent HSC staff, not to elevate the ego of trainers at the expense of learner confidence.

[xx] This can be due to non-inclusive working environments; also in some countries outside of UK, it can be considered culturally disrespectful to challenge authority.

Good Practice Example - Fairer Feedback

The General Medical Council (GMC) offers "Fairer Feedback" workshops to improve the quality and fairness of feedback in medical education.

This initiative aims to address issues related to feedback in postgraduate medical education and its impact on doctors in training and trainers, with a particular focus on disparities in educational outcomes.

Commitment to reducing inequalities in medical education and training

The GMC has set a target to eliminate discrimination, disadvantage and unfairness in education and training by 2031. Research by the GMC has identified that underrepresented groups of doctors, particularly those from minority ethnic backgrounds and international medical graduates (IMGs), may face systematic disadvantages in medical training, leading to differential attainment.[xxi]

The international medical graduate proportion of medical workforce in NI has doubled within the last 5 years and now represents 10% of the overall workforce; proportion of international medical graduates within the first year of GP training is currently 52%.

Workshops:

In 2025, GMC made a commitment to NIMDTA to offer fairer feedback conversations to all GP trainers across Northern Ireland. Fairer feedback conversations are also offered at all HSC Trusts as part of the "trainer forum" model.

The purpose is to improve the quality and fairness of feedback conversations in medical education. 2.5-hour workshop covers the following topics:

1. Differential attainment: what is it, what the GMC is doing, risks and protective factors;
2. Feedback conversations: impact, effective feedback conversations, feedback models;
3. How to make feedback conversations fairer: cultural competencies, humility, micro-validations.

Outcomes:

Participants have reported positive experiences of the workshops, meeting learning objectives and improving confidence in delivering Fairer Feedback.

GMC continues its programme of delivery of Fairer Feedback workshops.

[xxi] Differential attainment refers to the observed differences in outcomes when comparing groups based on protected characteristics and socio-economic background

Red Flag Behaviours

1. Failure to receive constructive challenge in the way that it is intended, such as:

- Accusations of undermining in response to constructive challenge;
- Lack of willingness to take on board feedback to improve safety.

2. Punitive action towards those who provide constructive challenge, such as:

- Bullying, isolation, exclusion, unfairly labelling staff who constructively challenge as 'difficult'.

3. Low rates of constructive challenge in situations where it would normally be expected i.e.:

- Meetings to discuss complex cases, morbidity and mortality meetings etc.

Expectation 18: Speaking up is highly valued and encouraged, and results in action to improve patient safety

18.1 HSC Trust Boards ensure there are clear mechanisms in place for staff to safely raise concerns about patient and staff safety. These should include formal mechanisms for 'raising concerns' and may also include:

- HSC Trust Board Level Speak Up/ Raising Concerns Champion;
- Informal mechanisms through Leadership WalkRounds[36], Listening Exercises, Staff Forums, Story Boxes.

18.2 HSC Trust Boards integrate both quantitative and qualitative information from 'raising concerns' in their metrics for safety.

18.3 HSC Trust Boards actively seek out and monitor feedback from staff experiences of raising concerns through an independent channel. Learning from poor experiences is captured and improvements implemented.

18.4 HSC Trust Boards seek assurance that concerns raised by staff, results in action to improve safety, and does not result in detriment to the staff members raising concerns.

18.5 Raising concerns is a standing item at HSC Trust Board Patient Safety and Quality Committees; information provided should include an overview of the concern raised, action taken to address concerns and support staff.

18.6 Raising concerns is normalised within the organisation and embedded within day-to-day operational activities.

18.7 There is evidence of patient safety improvements following patient complaints and staff raising concerns.

18.8 When staff members raise concerns at team level or above, there is collective ownership for addressing the concern, ensuring that the focus of any subsequent process becomes the concern itself and not the individual raising it.

18.9 HSC Trust Boards and Senior Leaders promote the benefits of speaking up by demonstrating that speaking up results in action to improve patient and staff safety. They may share examples of speaking up leading to system improvements.

18.10 HSC Trust Boards and Senior Leaders consistently ensure support and protection from unfair treatment for those who raise concerns. Senior Leaders seek to prevent and tackle any negative impact experienced by employees, as a result of speaking up about patient safety.

18.11 There is training and awareness for staff at all levels on: mechanisms to raise concerns; formal procedures; support available; and statutory entitlements and protections from victimisation under Public Interest Disclosure legislation.

18.12 Staff at all levels feel actively encouraged and supported to raise concerns.

18.13 Staff feel confident raising concerns and do not fear negative repercussions as a result.

18.14 All staff who raise concerns are provided with meaningful support (for e.g. – peer support or a buddy system) along with a dedicated mechanism to escalate any concerns about unfair treatment or victimisation that may arise.

18.15 Staff at all levels, of all roles and grades, feel safe and confident to report incidents, errors and mistakes.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

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3.4 Speak Up Culture

'Staff are the HSC system's most powerful resource in identifying concerns about patient safety' – that is, if they are enabled to be.

There remains a disconnect between intention and reality, what on paper looks like an effective system, in practice may not be; this is not unique to NI, as it exists across the NHS.

Professional regulators state that Health and Social Care professionals must speak up if they have concerns about patient safety. All HSC Trusts have systems and procedures in place for raising concerns:

- Incident reporting;
- Escalation of concerns;
- Internal whistleblowing/raising concerns policy for raising serious concerns (i.e. making a protected disclosure in the public interest).

Furthermore, organisations have a statutory 'duty of quality' for patients, a 'duty of care' to staff; staff raising concerns about patient safety, have whistleblowing protections set out in law.

However, stipulating that staff 'must' raise concerns and having systems and processes, and even statutory protections in place, does not always address the biggest barrier to staff speaking up - 'Fear'.

Sadly, there are legitimate reasons for staff to be afraid. Research on the experiences of 'NHS whistle-blowers' shows that staff who raise concerns may experience:[37]

- Extreme stress during the whistleblowing process;
- Organisational retaliation and reprisal, including disciplinary processes, referral to professional regulators, and unfair or constructive dismissal;
- Victimisation by colleagues through impact on career progression; bullying; ostracisation;
- Failure to achieve the desired outcome of safeguarding patients from harm.

It is unacceptable that staff are harmed in the process of raising concerns about patient safety, when they have both a professional and moral responsibility to act.

Furthermore, it is unethical to demand that staff speak up, if concerns are ignored, and staff silenced, disempowered, or harmed through retaliation and/or victimisation.

Not only is this approach counter to the ethos of **'Patient Safety is Paramount'** and **'Staff Wellbeing is Core Value'**; it is antithesis of a just, open and learning culture.

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HSC organisations can foster a 'Speak Up Culture' through the following actions:

1. Senior leaders role model positive behaviours in relation to raising concerns;
2. Act on concerns in order to improve patient and staff safety;
3. Make it is safe for staff to raise concerns;
4. Value staff who raise concerns;
5. Normalise raising concerns;
6. Celebrate improvements following raising concerns.

The behaviours and reactions of senior staff in response to challenge determines whether staff feel enabled, empowered and safe to raise concerns about patient safety.

Senior leaders who excel in fostering a 'speak up culture' are:

- Proactive about seeking concerns – they 'test the silence' and 'do not assume that no news is good news';
- They are visible, accessible and proactively speak to staff, patients and families at the coal-face in order to know where the problems are;
- They adhere to the principle of 'you cannot un-know what you know', by taking ownership of the problem;
- When issues are raised that reflect poorly on their leadership they do not see it as an inconvenience or betrayal but rather as an act of kindness – providing HSC organisations and Senior Leaders with an opportunity to rectify problems and do better;
- They foster collective ownership for addressing concerns, shifting the focus away from the individual raising the issue, to appropriately reviewing, understanding and resolving the issues in order to safeguard patients.

They ensure that staff who raise concerns are appropriately supported and safeguarded from victimisation and retaliation, and they hold staff, who bravely put their 'heads above the parapet', as role models for patient safety.

'Whistleblowing is not an inconvenience or betrayal - it is an act of moral courage, integrity and kindness'

Good Practice Example - RQIA Speak Up Champion

RQIA is committed to creating an environment where RQIA staff safe and supported to 'speak up' with confidence that RQIA will listen, and will respond, using fair and rigorous processes.

As part of this commitment, Sarah Wakfer, an RQIA Authority Member, has been appointed as the Authority's Speak Up Champion.

The role of the Authority's Speak Up Champion is to be a set of ears for RQIA staff to speak to about any concerns at work. The Speak Up Champion is an accessible point of support, who helps signpost and empower staff, ensuring that all staff have a voice that counts.

The Speak Up Champion's role is to listen impartially and signpost people to all available routes that can offer resolution, including relevant Policies and Procedures.

The Authority hold regular discussions, led by the Speak Up Champion, to consider thematic information emerging from the role to inform wider learning and actions.

RQIA staff who have engaged with Sarah report a very positive experience of having their concerns listened to and receiving impartial advice.

The RQIA Speak Up Champion Role has played an important part in fostering a Speak Up Culture within RQIA.

Red Flags

1. **Low Raising Concerns Rates – through both formal and informal channels**

2. **Whistleblowing to external agencies**

3. **Evidence of unfair treatment of staff following raising concerns:**

   - Exit Interviews;
   - Grievances;
   - Employment Tribunals arising from unfair treatment of whistle-blowers.

Expectation 19: Time and space for reflection is created at all levels in the organisation

19.1 Senior leaders promote a culture of reflection within the organisation.

A narrative is promoted that reflection is essential and is a positive, empowering teams to reflect on what has gone well, as well as what needs to improve.

19.2 Time and space for reflection is created at all levels in the organisation.

This will depend on the particular setting but may include dedicated time within job plans or protected time within the working week for teams to meet and reflect.

19.3 Senior Leaders demonstrate a consistent drive for curiosity and self-reflection, which involves:

- Having the confidence to 'hold up the mirror' and reflect on how they may do things differently
- 'testing the silence' on matters with respect to staff and patient safety
- Being genuinely curious about organisational performance with respect to just, open and learning culture

19.4 Senior Leaders proactively gather information to understand the value added by HSC services, the impact on the health and wellbeing of the workforce, the local population, and to identify areas for improvement:

- 360 degree appraisals;
- Leadership Walk-Rounds;
- Mechanisms for engagement with staff;
- Mechanisms for engagement with communities e.g. Local communities, Councils, Community and voluntary sector.

DoH Quality Standard 5.3.3 Promoting Effective Care

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3.5 Creating a culture of curiosity and reflection

Cultivating a just, open and learning culture requires a curious mindset and time and space for reflection to be embedded at all levels within the organisation.

At a clinician level it is well established that reflective practice encourages improvement in clinical practice. It enables Health and Social Care professionals to reflect on what has happened, what has gone well and what requires improvement, and to determine an action plan to take those improvements forward.

Just as Health and Social Care professionals reflect on their clinical practice, the HSC system needs to take time to intentionally reflect on organisational practices.

This requires HSC Trust Boards and Senior Leaders to build time into their everyday work to understand how organisational strategies and operations are impacting on organisational performance, efficiency, staff wellbeing, quality and safety of patient care; and to identify where the organisational approach may benefit from improvement, as well as celebrating and capitalising upon successes.

It also creates space for curiosity – to think about impact, how things may be done differently and how things are done elsewhere.

Curiosity is increasingly recognised as beneficial for driving learning and improvement.

IHI sets out five simple rules for curious leaders:[38]

1. Ask rather than tell;
2. Listen to understand rather than respond;
3. Hear every voice rather than those easiest to hear;
4. Prioritise problem framing rather than problem solving;
5. Treat vulnerability as a strength rather than a weakness.

There is recognisable commonality with compassionate leadership, with similar advantages in fostering psychological safety, inclusion and staff wellbeing.

Curiosity is also a key characteristic of an effective HSC Trust Boards, who under a 'duty of quality' must **'seek assurance, not reassurance'**, around patient and staff safety, including assurances that a just, open and learning culture is being fostered within the HSC organisation.

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Red Flag Behaviours

1.Lack of curiosity

- Lack of curiosity within the organisation – 'no news is good news'.

2.Failure to listen

- Staff, patient and family feedback not acted upon.

3.Denial of problems

- Leaders and managers maintain a narrative that 'everything is fine';
- Lack of willingness to accept or understand problems.

4.Resistance to reflection

- Lack of willingness to consider alternative approaches or improvements;
- No downtime for reflection.

Expectation 20: Learning is shared in a way that is meaningful and has impact

20.1 There is a HSC Trust-Board and Senior Leadership commitment to identify learning, which includes learning from good practice as well as learning from harm, and to ensure that learning is shared in a meaningful way with frontline staff, and has a measurable impact.

20.2 Feedback Loops are maintained, whereby the impact of learning and improvement, positive or negative, can be promptly identified and addressed.

20.3 Senior Leaders are as committed to learning from excellence, as they are to learning from harm.

20.4 Leaders and managers, are committed and supported to seeking out examples of good practice.

20.5 Approaches such as appreciative inquiry[xxii] and investigating success are embedded within services and teams.

20.6 When good practice is identified, there is a desire to share it, and to consider scale and spread.

20.7 Learning from incidents and complaints is shared in a way that is meaningful and has impact.
[See Good Practice on Page 97]

20.8 At all levels, there is a shift away from a tick box approach to sharing learning and towards one that strives to achieve and demonstrate measurable impact.

20.9 Robust communication plans ensure that learning is shared with staff by a variety of means, appropriate to the specific service(s).

20.10 Where relevant, learning is embedded within education programmes, staff guidance, QI initiatives.

20.11 Senior Leaders and Team leaders have responsibilities for sharing information and providing feedback on how the learning has been utilised to drive improvements, and its impact.

20.12 Senior Leaders proactively engage with staff, patients, families and local communities to understand the value added by HSC services, the impact on the health and wellbeing of the workforce, the local population, and to identify areas for improvement.

DoH Quality Standard 5.3.3 Promoting Effective Care

[xxii] Appreciative Inquiry is a strengths-based approach to driving change that focuses on building on what is already working well. Instead of focusing on problems, Appreciative Inquiry encourages participants to explore past successes and envision future possibilities to drive innovation and positive change. It uses questions to elicit positive stories and collaboratively create a shared vision for the future.

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3.6 Sharing Learning in a meaningful way that has impact

Learning is a fundamental part of a safe, effective and continually improving system. This includes learning from good practice as well as from when care goes wrong.

'Learning from Excellence' recognises that despite system complexity, human factors and a large number of variables, most of the time care is satisfactory and outcomes are good. The benefits go beyond improving staff morale through recognition; there is value in understanding and replicating the key ingredients to success in order to improve consistency and reliability of systems for safe delivery of care. There needs to be a cultural shift towards identifying and sharing the good practice, not with the primary motivation of recognition, reward and praise, but for the purposes of improving the HSC system (which is reward in itself).

When care goes wrong we must also learn. If we do not learn, then we will not improve. We must also be assured that what we have learnt has been used to drive improvements, and that these improvements have had the desired impact on patient safety.

> "It is a learning process and if we don't do learning we are never going to move on... If you make a mistake, and you ignore that mistake... then you're only going to keep making the same mistake, time and time again..."
>
> Norma Sparkes, Mother of Stephen Sparkes

Despite the myriad ways in which learning can now be shared, this has become increasingly challenging in our complex, highly pressured and busy HSC system. It is incumbent upon the HSC system to ensure that when incidents and complaints have been investigated and reviewed, be it through HSC Trust processes or external processes, that the learning is embedded to make clinical practice, systems and processes safer for patients going forward.

This requires moving beyond a 'tick box approach' to sharing learning and being very intentional in how we get the key safety messages shared so that they are not forgotten and enter into the collective consciousness of 'how we do things around here'.

> "The implementation process must become a seamless part of the [learning] process. Nothing should be signed off [as implemented] until physical verification of the implementation of change has been carried out."
>
> Expert by Experience

20.7 Good Practice in Sharing Learning from Incidents and Complaints

Robust communication plans ensure that learning is shared with staff by a variety of means, appropriate to the specific service, such as:

- Team meetings and huddles;
- Governance meetings;
- Staff training and education sessions and events;
- Written information: leaflets, posters, letters, emails;
- Videos, podcasts, infographics.

Where relevant, learning is embedded within education programmes, staff guidance, QI initiatives.

Red Flag Behaviours

1. Failure to implement improvement plans or recommendations;

2. Failure to check implementation;

3. Recurring serious adverse incidents due to failure to implement learning;

4. Poor corporate memory in relation to previous learning.

Domain 3: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Public Interest Disclosure (NI) Order 1998;
- NIAO Good Practice in Raising Concerns;
- NIPSO HSC Model Complaints Handling Procedure;
- CQC Best Practice Guidance;
- NICE Guidance – Practical Steps to Improving Quality of Care.

Conclusion

Being Human: A Framework for Safety Culture within Health and Social Care sets out what a good safety culture looks like within HSC in Northern Ireland. It defines safety culture as one that is 'Safe and Compassionate', 'Just and Open', and 'Continually Learning and Improving'.

Recognising that culture, shaped by values, attitudes and beliefs, is characterised by the complexity of human interactions and behaviours, 'Being Human' delineates a shift away from rigid process-driven, 'tick box' approaches to Health and Social Care. Instead it focuses on our shared humanity and embedding a relational person-centred ethos at all levels of HSC; understanding that authentic human connection, and the relationships we have with each other as patients, family members, HSC staff, and leaders, are our greatest asset to ensuring a safe high-quality HSC system.

It identifies compassionate leadership as fundamental to all other aspects of safety culture. When HSC senior leaders authentically exhibit and role model the behaviours of active listening, empathising, understanding and responding with meaningful action, we foster organisational cultures that embody HSC values and remain true to the founding principles of HSC, fulfilling a 'duty of quality' to patients and 'duty of care' to staff.

There is an intrinsic link between staff wellbeing and patient safety that must be recognised and continually nurtured. With its antecedent arising from the voices of those who have experienced healthcare-related harm, the Framework sets out the requirements for 'compassion, civility and respect' to be embedded within the HSC system, not just for patients and their families, but for HSC staff.

Respect necessitates listening and acting. Patients and families need to be heard and where concerns are raised, feedback should be provided on system learning and improvement; even better, when patients and families can be involved in making those improvements.

Staff need to feel confident that they will be listened to, as well as supported and protected from unfair treatment, should they 'put their heads above the parapet' and raise concerns about safety. The staff voice needs to be recognised and celebrated as HSC's most powerful resource in preventing harm to patients.

By listening, hearing and acting in response to staff, patient and family voices, HSC organisations can take preventative and early action to address issues with staff and patient safety. Where staff and patients are afforded psychological safety, high-quality care will be protected and flourish.

Unfortunately, care will not always go according to plan and it is inevitable that some people will experience poor outcomes. As we strive to reduce avoidable harm, it is incumbent upon all of us as individuals, to demonstrate accountability by owning our actions, being open and honest, learning from mistakes and contributing positively to system learning and improvement.

It is equally incumbent upon HSC organisations to foster a just, open and learning culture in the understanding that most of the time safety incidents occur, not as a result of deliberate negligence or wrongdoing, but as a result of an interplay between system and human factors.

Blaming and punishing staff for mistakes does not improve patient safety but rather leads to defensiveness, secrecy, and compounded harm; patients and families do not receive the answers they need to move forward, and neither does the HSC system.

Evidencing a just and open culture is crucial to lessening fear and defensiveness within the HSC system. In the absence of fear and defensiveness, early apology, openness and honesty, restorative action and learning, is more likely to be forthcoming in order to support healing and recovery for all individuals impacted; patients, victims, their families and HSC staff.

A just culture is essential for an open culture; and an open culture is a pre-requisite for a learning culture. Continuous learning and improvement, also require curiosity, constructive challenge, time and space for reflection, at every level of the HSC system; particularly at senior levels, where consideration should be given to how to scale up and spread good practice, as well as how to address poor practice, and do things differently.

Recognising that ‘culture comes from the top’, the Framework will be of particular benefit to HSC Trust Boards, and newly established Patient Safety and Quality Committees, as they determine how best to improve and assure safety for staff, patients and the public. It is not a one-off and standalone piece of work, but rather the continuation of an onward journey.

In the short-to-medium term, further work is required to develop the tools, guidance and adjuncts necessary to facilitate Framework implementation and evaluation. In the longer term, it will require whole-system adoption in order to maximise safety culture within all aspects of Health and Social Care.

Meanwhile, the Framework should be harnessed and utilised to shift mindsets, influence behaviours and define the actions required to embed a ‘safe and compassionate’, ‘Just and Open’, and, ‘Continually Learning and Improving’ culture within HSC.

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Glossary of Terms

Term	Description
Agency Worker	A HSC agency worker is someone employed by an employment agency who provides temporary or interim staff to HSC organisation. The agency worker's contract is with the agency, not directly with the HSC trust they are working for.
Burn Out	Burnout is emotional, mental and physical exhaustion which arises from prolonged period of stress.
Candour	Being open and honest when care goes wrong.
Constructive Challenge	Constructive challenge refers to the practice of asking questions and offering feedback in a way that is designed to improve decision-making, performance, and overall quality of care, while maintaining a positive and collaborative environment. It is a vital aspect of good governance and leadership, particularly within Boards and committees.
Continuing Professional Development (CPD)	Continuing Professional Development (CPD) refers to the process of maintaining and enhancing the knowledge, skills, and experience necessary for professional practice.
Co-production	A way of working where people who use services, carers, and professionals collaborate as equal partners in designing, delivering, and evaluating services. It emphasises shared decision-making and recognises that individuals with lived experience possess valuable expertise that should be integrated into the process.
Coroner Investigations	Coroners are independent judicial officers who investigate deaths reported to them. They will make whatever inquiries are necessary to find out the cause of death, this includes ordering a post-mortem examination, obtaining witness statements and medical records, or holding an inquest.
Department of Health (DOH)	The Department of Health (DoH) is responsible for health and social care, public health and public safety in Northern Ireland. It has a mission to improve the health and social wellbeing of the people of Northern Ireland.
Diversity	Diversity refers to the presence of a variety of people from different backgrounds, experiences, and characteristics within a workforce or service user group. It encompasses a broad range of factors, including age, gender, ethnicity, race, religion, sexual orientation, disability, and socioeconomic background.
Duty of Quality	The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1] applied a statutory duty of quality on the HSC Board and Trusts. This means that each organisation has a legal responsibility to ensure that the care it provides must meet a required standard.

Term	Description
Experts by Experience	An expert by experience, has gained their expertise through Lived Experience.
Evidence-based practice	Evidence-based practice is the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions.
Framework	A framework in healthcare refers to structured approaches or models that guide the delivery and improvement of healthcare services.
Group-think	A psychological phenomenon in which people strive for consensus within a group. In many cases, people will set aside their own personal beliefs or adopt the opinions of the rest of the group.
Governance	A system through which Health and Social Care organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
Health and Social Care (HSC)	Services available from health and social care providers across a variety of settings, including hospitals, care homes, agencies and community settings.
Health and Social Care (HSC) Trusts	Collective reference to all six HSC Trusts: · Northern HSC Trust · Belfast HSC Trust · Southern HSC Trust · South Eastern HSC Trust · Western HSC Trust · Northern Ireland Ambulance Service (NIAS)
Health Inequalities	Health inequalities refer to systematic and avoidable differences in health status between different population groups. These differences are linked to social, economic, and environmental disadvantages, meaning that some groups of people experience poorer health outcomes than others due to circumstances beyond their control.
Human Factors	Human factors, also known as ergonomics, is a scientific discipline focused on understanding the interactions between humans and other elements of a system.
Human Resources (HR)	Human Resources (HR) encompasses the management and support of staff. This involves a wide range of activities, from recruitment and training to implementing employment policies and fostering a positive work environment.
Informed Consent	Informed consent, means a patient agrees to a medical treatment, test, or examination after being fully informed about its benefits, risks, and potential alternatives.
Locum Personnel	Locum staff are individuals who temporarily fill a vacant position or shift.

Term	Description
Martha's Rule	Martha's Rule, implemented in England and Wales in April 2024, enables staff, patients and their families to seek an independent medical review if they feel their concerns about a patient's care are not being adequately addressed.
Moral Distress	Occurs when Health and Social Care professionals experience psychological unease due to constraints that prevent them from acting in accordance with their ethical values and beliefs.
Moral Injury	Psychological harm experienced by Health and Social Care professionals when their actions, or inactions, conflict with their moral or ethical code.
Multi-agency Approach	A multi-agency approach in the NHS involves different services working together to improve outcomes for individuals, particularly those with complex needs or those requiring safeguarding. This collaborative effort aims to pool resources, expertise, and information to provide a more co-ordinated and effective response.
Multi-disciplinary Approach	Involves professionals from various disciplines working together within a single organisation or team to provide comprehensive care to patients.
Never Events	In HSC (Health and Social Care), a "Never Event" is a serious, largely preventable patient safety incident that should not occur if existing national guidelines and safety recommendations are followed. These events are considered preventable because strong, systemic barriers should be in place to prevent them.
NICE	National Institute for Health and Care Excellence. Produces evidence-based guidance for the NHS and wider health and social care system.
Non-Executive Directors	Non-executive directors work alongside other non-executives and executive directors as an equal member of the HSC Trust Board. They share responsibility with the other directors for the decisions made by the board and for success of the organisation in leading the local improvement of healthcare services for patients.
Northern Ireland Public Services Ombudsman	Investigate unresolved complaints about public bodies in Northern Ireland. Investigations check to see if a public body acted properly or whether someone was treated unfairly. When things go wrong they suggest what can be done to put things right.
Patient	The Department of Health acknowledges that the HSC system utilises a range of terminology for individuals using services. While not exhaustive, it includes terminology such as service recipient, client, individuals who receive social work/social care support and/or service users. For the purpose of this document, it was agreed that the term 'patient' would be used throughout recognising that it is an umbrella term for an individual in receipt of Health and Social Care Services.

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Term	Description
Patient Client Council	The Patient Client Council (PCC) is a statutory body which provides an independent voice for the public on health and social care issues across Northern Ireland.
Patient Safety Culture	The extent to which an organisation's culture supports and promotes patient safety. A safety culture within HSC is one that is that is safe and compassionate for patients and staff, just and open, and continually learning and improving.
Person Centred Care	Working in partnership with patients to meet their medical, psychological and social needs. It can be described as personalised, co-ordinated and enabling, and involves treating patients with dignity, compassion, and respect.
Primary Care	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
Professional Regulators	Professional Regulators, such as the General Medical Council and Nursing and Midwifery Council, provide oversight and certification to specified regulated occupations. Professional regulators have a duty to regulate their professions in the public interest, which may not necessarily reflect the interests of their registered professionals.
Psychological Safety	Staff feel safe to ask questions and learn, safe to discuss ideas on how to improve, and safe to communicate and raise concerns so that patients and staff can be safeguarded from harm. Patients and families, are empowered, supported and enabled to raise concerns about care and treatment, to have their voices listened to so that the HSC system can learn and improve.
Public Inquiry	An official investigation established by a government minister, under the Inquiries Ac 2005[1] to examine matters of public concern regarding specific events or actions. These inquiries are conducted by an independent body and aim to provide transparency and accountability in addressing significant issues that affect the public.
Quality Management System (QMS)	An approach to quality management that integrates quality planning, quality control, and quality improvement activities across the organisation, supported by leadership practices that foster a culture of learning.
Regulation and Quality Improvement Authority (RQIA)	Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Safe Staffing	Ensuring there are enough qualified, skilled and experienced people, who receive effective support, supervision and development to work together effectively to provide safe, effective care.

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Term	Description
Safety Management Systems	A Safety Management System (SMS) is a proactive and integrated approach to managing safety. It sets out the necessary organisational structures and accountabilities to ensure that safety is integrated into an organisation's day-to-day activities. SMS incorporates four broad areas: Safety Policy; Safety Risk Management; Safety Assurance; Safety Promotion.
SBAR (Situation-Background-Assessment-Recommendation)	SBAR is an acronym that stands for Situation, Background, Assessment, and Recommendation. It's a structured communication tool used to convey critical information, especially in healthcare settings, to ensure clear and concise communication between professionals. The SBAR framework helps to standardise communication and improve patient safety by providing a consistent way to share information and escalate concerns.
Secondary Care	Secondary care is specialised medical care typically provided by Health and Social Care professionals upon referral from a primary care provider. It encompasses diagnostic, therapeutic, and surgical procedures delivered by specialists in hospitals or specialised clinics.
Second Opinion	When a service user chooses to see another healthcare professional, typically a doctor or specialist, after being given a diagnosis or treatment plan for a medical condition.
Senior Leadership Team	Is a group of senior managers who lead the strategic direction and operational management of the HSC in Northern Ireland. This team, often including a Chief Executive and Directors, is responsible for various aspects of the HSC, including setting priorities, monitoring performance, and ensuring effective service delivery.
Service Users	Service Users - individuals who receive care or services across a range of HSC services and settings.
Shared Decision Making	Health and Social Care professionals and patients working in partnership to make informed decisions about treatment and care. NICE guidance on Shared Decision Making promotes patient-centred care, ensuring that individual preferences, beliefs, and values are considered in the decision-making process.
Strategic Planning and Performance Group (SPPG)	The Strategic Planning and Performance Group plans and oversees the delivery of HSC services for the population of Northern Ireland. The Group is part of the Department of Health and is accountable to the Minister for Health. It is responsible for planning, improving and overseeing the delivery of effective, high quality, safe HSC services within available resources.
System Partner/s	A range of HSC organisations, agencies and registered providers, collaboratively delivering HSC care.
Trauma Informed Practice	A model that acknowledges the impact of trauma. It guides how healthcare and social care professionals engage with those affected. It considers the prevalence and impact of trauma. This approach adapts the delivery of care to support healing and avoid re-traumatisation.

https://www.rqia.org.uk/wp-content/uploads/2026/01/Being-Human-Framework-for-Safety-Culture-A4-DIGITAL-Doc-160126-compressed.pdf

Term	Description
Trust Board	A Trust Board functions as the corporate decision-making body. It has Executive and Non-Executive members who are full and equal members. Their role is to provide effective leadership, strategic direction and management of the Trust's activities. It is accountable, through the chairman, to the Permanent Secretary at the Department of Health Social Services and Public Safety, and ultimately to the Minister for Health.
Unwarranted Variation	Variation in care quality and safety that cannot be explained by patient need or preference. It can be due to inconsistencies in service planning, design and delivery, workforce issues and variations in clinical practice.
Whistleblowing	A term used to describe a situation where a worker raises concerns about wrongdoing in the workplace. Also referred to as 'raising concerns in the public interest' or 'making a protected disclosure'.

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www.rqia.org.uk/BeingHuman
info@rqia.org.uk

09/25

BELONGING

GROWING

WELLBEING

In summary our people priorities for 2026-2027 are:

1.

Develop and launch our revised People Framework 2025-2030 in line with our Vision and Strategy 2030 and identify directorate action to support delivery of our strategic priorities.

2.

Ensure organisational readiness for the implementation of the Equip programme; a Health and Social Care Northern Ireland (HSCNI) wide programme to replace the existing Human Resources (HR) Finance and Procurement systems with a single cloud-based solution.

3.

Deliver on year 1 of our wellbeing action from our newly revised Health and Wellbeing Framework 2025-2030.

4.

Establish a workstream to plan for the implementation of the regional 'Being Human – A Framework for Safety Culture'.

5.

Establish a cross directorate collaborative forum to develop the 'Southern Trust Academy' concept to develop a unified approach to leadership development and the broader development of all our people, aligned to our Trust Strategy and People Framework

6.

Establish strategic resourcing fora to drive forward key resourcing strategies and stabilise our workforce.

confidential Trust Board meeting immediately following the workshop.

At the ensuing confidential Trust Board meeting on 27th August, Dr. O'Kane brought to the Board's attention the SAI investigation into concerns involving the urologist in question. Members requested a written update for the next Trust Board meeting." 14:34

Then you say: 14:34

"This item was then brought to the next confidential Trust Board meeting on 24th September 2020 with a detailed paper provided by Dr. O'Kane and presented by Dr. Damien Gormley. This is also when board members other than the Chair were first notified that an Early Alert had been submitted, although the date of its submission was not clarified until the meeting of 22nd October. Further updates were provided to the Board on 12th November 2020 and 10th December 2020 and the issue has subsequent remained on the confidential Trust Board agenda." 14:34 14:35

Just the earlier paragraph, you mentioned the SAI and the information that was provided, what's the position now when SAI information is provided to the Board, is there more of an interrogation of the governance themes even while the investigation is ongoing or do you find out about it at the end, what's the current process? 14:35

A. What has happened is in relation to serious adverse incidents, a serious SAI that has come to us, they are all serious, but a significant one has come to the Board, it will come with an action plan, an update on an action plan from the appropriate directors. That will be quizzed then by the board members, then with either an update to come back at three or six months, depending on the nature of that. In some cases it maybe delegated down to a committee for closer observation. 14:35 14:36

176 Q. We talked earlier about the box or the escalation table that had to be filled in and that was a way of triggering people to remember about that, is there anything similar at Board level that prompts consideration of patient safety issues or risk in SAIs or any other governance, does anyone automatically say 'okay, that sounds like we need to do a risk assessment or look at patient safety', is that an ad hoc thing or is it more formal? 14:36

A. It's not formal, it just happens. It will either come from a Member of the Board or indeed the director reporting may highlight that there is a patient safety issue. If you want I can give you a short example? 14:36

177 Q. Yes, please.

A. Okay. So, our Director of Nursing, Allied Health Professional and Midwifery reported to a Governance Committee meeting, at the end of the meeting, only some months ago about concerns that she had in relation to one of our wards within Craigavon Area Hospital. It's 14:36

partners along with the different directorates. Now, it's on the premise that there has to be a really close working relationship with these directorates, because we are completely dependant on their expertise and local knowledge to actually understand but also to try and help us develop and standardise what's going on there so that we're not getting these pockets where actually business is done differently and runs the risk of being unsafe.

155 Q. Yes. So you are no longer - so as an organisation you're no longer isolated as a senior management team from what is going on within each of the directorates, because there is now an energy or a requirement propelling the information out of the services up towards the top table on a very frequent basis, is that the position?

A. Yes. And I think, I mean I think the weekly governance report helps with that, and there is an expectation that we, you know, if anybody is worried about anything that they raise it. And, again, it may not be something that we're going to react to immediately, but in terms of building up the knowledge level of, you know, or taking, you know, a temperature check in relation to the organisation, all of that information is really useful. So, you know, we actively encourage people to speak up. And, again, you know, back to the piece of cultural work that we have started across the organisation in relation to being open, which came out of the IHRD Inquiry, and the work that Justice O'Hara

did, and the work then that we're pursuing in relation to being open and developing an open and just culture, all that of is embedded in that as we try to take that forward.

156 Q. Okay. Well we've touched upon a number of strands, hopefully with a degree of connectiveness by way of overview over the last 50 minutes or so. I want to go back a little. I want to ask you about, I suppose the External Reference Group is my starting point, but I think the Inquiry wants to get a sense from you about where the Trust is going from now. Having completed something of the journey, what are the next steps? So in terms of the External Reference Group leading in to the work that's been done around the Trust's vision through, I think it's Mrs. Wilson, is that right? 14:47 14:48 14:48

A. Yes, she's Director of Performance and Planning and Informatics.

157 Q. Yes.

A. Yes.

158 Q. And the work that's going to go into the five-year strategy. Could you help us first of all in terms of the External Reference Group. You've kindly supplied the Inquiry with a lot of papers in relation to it. The Inquiry is interested to know the origin of that group, why it was brought together, and what has it's role been over the past several months? 14:48 14:49

A. Okay. I think I was - I think we all where, but I know that I was particularly shocked by the fact that we'd had this blind spot that we discovered in the summer of

appreciative of the excellent care and treatment received at 2 South CAH we enquired initially to Sister O'Hagan how could we repay or give back something to this department. Sister O'Hagan said she would discuss this with the then only Consultant Mr O'Brien. Some weeks later (this was 1994) We had a first meeting with Mr O'Brien and Sr O'Hagan to discuss what we as family could contribute to the ward. After a further few weeks we agreed that Sr O'Hagan and I would be Co-founders of a charity called CURE (Craigavon Urological Research and Education). CURE was properly and professionally established with a goal of providing funding for this service to purchase stone therapy equipment and provide research and education for doctors and nurses.

Many thousands of pounds were raised by my family, ward staff and many other patients. No money was ever contributed by the Southern Trust to CURE. Directors of Finance at the Trust Personal Information redacted by USI *both were members and I think other Directors. Mr Michael Young was the either the second or third Consultant appointed to Urology department and Mr Young joined the Cure Committee. We had many external professionals and business people serve as Committee members.*

Mr O'Brien, and his wife, along with many other Consultants, attended many fund-raising events for Cure and other Charities e.g., the hospital Drs Ball.

Every 12-18 months, Mr O'Brien and his wife would attend a dinner with my husband and me. When Sister O'Hagan sadly died, her husband remained a great friend to Urology and CURE so he too would attend the dinner.

Mr O'Brien and his wife were invited to and attended three of our children's weddings over the past 15 years. I have attended one of his son's weddings. Our children were very young when I first became ill. Attending CAH and having Personal Information redacted by USI *became part of our family life, Urology was a regular discussion in our family and extended family. My family were and are forever grateful for the excellent care I received in Urology services.*

plan and they went off to stay with other family members. So Mr. O'Brien's name in our home was very important. I'm sorry for saying, and I've no problem in declaring that, he was a very important person in our home and in our life because of the path we had, so we did become friends and in that way a friendship. And he attended our children's wedding because - sorry for saying this - but one of my comments always was when I was ill, if I could just live to see my children go to school, that was all I asked. With the care and treatment plan from Mr. O'Brien and the team of other people, I had longevity more than I ever expected. So therefore, to see my children get married, part of that was actually looking back a journey that I was grateful to for the contribution of not just Mr. O'Brien, other people. I mean Mr. Young as well, other people in the Urology Department, and in the Republic of Ireland, you know, made my recovery work. I am indebted to that to this day, that I have been able to see my children married and that is why he was there at the wedding. So, there's nothing hidden about that.

11:21
11:21
11:22
11:22

13 Q. Yes. There's absolutely no reason to apologise for saying that; that's entirely valid and appropriate that you should say it.

11:22

In terms of his view of your friendship, he reciprocates the remarks that you have made. In his evidence, Mr. O'Brien has described you as good friends and he set out the value that he has, that he places on

context:

"Mr. O'Brien and his wife, along with many other consultants, attended many fundraising events for CURE and other charities."

You say every 12 to 18 months, Mr. O'Brien and his wife would attend a dinner with your husband and yourself, and when Sister O'Hagan sadly died, her husband remained a great friend to Urology and CURE so he too attended the dinner.

You go on to explain that beyond the work of CURE, Mr. O'Brien and his wife were invited to and attended three of your children's weddings over the past 15 years, and you have attended one of his son's weddings. So, is it fair to say that in terms of your relationship with both Mr. and Mrs. O'Brien, that from a point of not knowing him at all, the relationship became threefold - doctor and patient, co-director with him in CURE, and then blossoming out into a friendship which would have had social interaction, including attendance at notable events such as weddings?

A. Yes. Mr. O'Brien - with his wife because she was part of that partnership of course - Mr. O'Brien's name in our home was held in the highest regard by our children. Please remember, Mr. Wolfe, our children were very small when I was very sick. They were used with me going off quite a distance to have my treatment

you had made a complaint to her that Mr. Mackle had been bullying and harassing you. Did you make that complaint to her?

A. Absolutely not and, you know, I can give you some reasons why I wouldn't. Because we're neighbours, we're good friends. She had been my patient away back years ago. It would have been totally inappropriate to put someone who has done so much for urology by way of CURE in such a position. I would never have done it. So, the short answer is no. 14:57 14:58

166 Q. Thank you.

Would she, nevertheless, have known your unhappiness with how you felt you were being treated by Mr. Mackle?

A. I genuinely and honestly do not believe she would have any reason - certainly not from me or from any party in my family - to have known that. I can't think of -- no, I don't believe. 14:58

167 Q. So you're clear that to the best of your knowledge, no member of your family and certainly not yourself ever discussed your unhappiness regarding Mr. Mackle's management of you with Mrs. Brownlee? 14:58

A. That's right. I mean, my children wouldn't have been in a position to be doing that anyhow, so it's just my wife and I. No, certainly not. That has never arisen. Absolutely not. I'm saying it, I want to emphasise the no, because it's not just because to the best of our ability or memory or knowledge that it didn't happen. When you value someone like I value Roberta Brownlee, 14:59

canteen area. I "walked the walk as well as talking the talk" - I was a visible Chair. I liked to meet all grades of staff and made time to stop and have a brief chat.

I never formally or informally discussed urology services or Mr O'Brien with any member of SMT.

In all my years as Chair I never met with Mr O'Brien formally and have no notes of any meeting.

I never remember any of the Urology Consultants speaking to me formally re Urology services. I knew many of the Urology staff, but none came to me formally. I would have visited the canteen often during my tenure and met many staff including staff from the Urology Dept, during my travels. No one ever spoke to me formally or informally about clinical issues about Mr O'Brien.

It was only when Dr Richard Wright (then Medical Director) walked into my office (2016/2017 year- when Francis Rice was Interim Chief Executive) to inform me that concerns that had been raised about Mr O'Brien. Dr Wright did not go into any detail of the concerns during that discussion (referred to later in my statement). Then, in July 2020, Shane Devlin Chief Executive came to my office and said there were concerns being investigated regarding Mr O'Brien. Shane mentioned it was to do with storage of patients records not having been triaged and followed up in a timely manner. No further detail from my recollection was shared at that time.

No other member of the SMT, any other Urology staff ever raised any concerns with me formally or informally. The Leadership walks from my recollection had not picked up any Urology clinical concerns.

8. How is the Board informed of concerns regarding patient safety and risk?

Normally concerns regarding patient safety and risk would be brought to the attention of the Board via the CX or relevant SMT member to the Confidential Governance meeting or the Confidential Board meeting. The Governance Committee is a sub-committee (delegated schemes to Sub Committees) of the Board and Chaired by a NED. Meetings were held every three months.

long hand. When digital dictation was introduced for clinics, results, and discharge summaries he was slow to utilise it.

38. At various stages he was given support from his colleagues with triage. He was offered help by the Trust after his Job plan went to facilitation but didn't engage. He had twice as much secretarial support as his colleagues. Debbie Burns in 2014 asked him to say what support he needed to help his practice. That summer, he was given a month with no clinics to catch up on his administration. I don't know if it was arrogance or fear of losing face that stopped him from requesting more help / the help he needed to change his style of practice.

39. The failure to investigate the false accusation of bullying and harassment against me was, I believe, done for the best of reasons. I was aware at that time that Roberta Brownlee was very friendly with Aidan O'Brien and was a director of his charitable company 'CURE' from, I believe, 1997. Unfortunately, by not being investigated and exonerated I was told to be very careful in my dealings with Aidan O'Brien and as a result it reduced my ability to challenge him or his practice sufficiently.

40. The prevailing culture at the inception of the Trust was to maximise performance and to maintain financial stability. These main foci were also expected by HSCB. This drive for performance, while maintaining financial stability, may have distracted the Trust from quality issues. There was neither the time in the working day nor the support staff to undertake regular audits of outcomes and the patient pathway either solely within urology or when there was engagement with other departments like the cancer directorate, laboratories, radiology, theatres and outpatients.

41. The organisational structure for Medical Management of urology was Medical Director, Associate Medical Director, Clinical Director and then Lead Clinician. My role as AMD was extensive and demanding but at the same time, I was a full time General Surgeon with a special interest in Oesophagogastric as well as Colorectal Surgery. The nature of my general surgical post and the number of colleagues on the team meant that, if I was to free up extra time for the

ongoing concerns. I am aware that Mr Young, his colleague and Urology team lead, had a strong track record of supporting him. I understand that Mr O'Brien was a personal friend of the Trust Chair, Mrs Brownlee, but I am not sure what direct support, if any, that she may have offered.

65.How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1. Mr O'Brien raised some concerns about how his patients were to be cared for during his four-week period of exclusion in January 2017 and subsequent restrictions on his practice. The Acute Service directorate developed a plan in place to care for those patients within the urology team. Access times and medical staffing issues were generally on the corporate risk register and reviewed frequently, but there were no specific issues related to consultant urology between September 2016 and 2018. It would have been normal practice for the director of the relevant Service to bring such issues forward through their governance team. The Acute Services Director would be able to comment in detail on their own service risk register.

65.2. During the time period of my own involvement, I don't have any recollection of the concerns regarding Mr O'Brien being placed on the risk register, nor can I find evidence of same. It would not have been normal practice for issues that were the subject of an ongoing investigation to be placed on the risk register before a determination had been reached unless there were immediate safety concerns raised. We were being given assurances from the informal investigation by Mr Weir initially and eventually by the Case Manager, Dr Khan, that there were no immediate safety concerns. We were also reassured by the Acute Service Director (Mrs Gishkori) and her team that, during the investigation, Mr O'Brien was fully compliant with his return to work plan.

65.3. It is possible that the matters were discussed in confidential sessions of the Trust Board but I have no definite recollection of same.

173 Q. In her evidence on Tuesday, or at least she agreed with counsel's description of a chill factor arising out of the knowledge, personal to her, that Mrs. Brownlee had a friendship with Mr. O'Brien. First of all, do you recognise any sense of a chill factor created by knowledge of that relationship?

A. I think that, yes, I do recognise it. I am aware, because Maria O'Kane made me aware of the engagement between herself and the Chair. I was also aware of the fact, as I say, that Roberta was both a friend of Mr. O'Brien, an ex-patient of Mr. O'Brien, and latterly I was made aware that she was also the secretary of the charity that Mr. O'Brien had started for a period of time, not at the time that I knew her -- yes, not at the time -- a lot earlier. So I was aware of that. I was aware that, as I say, the conversation with Maria.

174 Q. Can I just bring you to that one specifically?

A. Yes.

175 Q. If we go to WIT-45034. Actually we'll go to WIT-40593. Thank you. If you scroll down the page, please. Dr. O'Kane was asked about issues of concern relating to Mr. O'Brien. She was asked:

Do you now know how long these issues were in existence before coming to you or anyone else's attention?

She's answered that question by saying:

Mrs. Brownlee volunteered to me that Mr. O'Brien had

saved her life, that she hoped I wouldn't raise concerns about Mr. O'Brien, as had been her experience previously with medical managers, that she that he had been poorly treated through the MHPS process and that he was an excellent surgeon.

Scrolling down please. She says it was a meeting on 11th January, it appears. She says:

I spoke to Mr. Devlin explaining that if there were concerns about any doctor I had a professional responsibility to pursue these concerns to assure patient safety, and he agreed.

The way that's been explained, it's not entirely clear in that bottom answer in blue, in the blue box, that she alluded, in her conversation to you, alluded to what Mrs. Brownlee had said to her.

First of all, do you recollect any conversation?

A. I do. My recollection is that she was reflecting on her first meeting with the Chair because Maria hadn't long started, had, in fact, probably been in about a week or so but I would have to check, reflecting on her first conversation with the Chair and did tell me that that's what the Chair had told her.

176 Q. You responded in what way?

A. I told Maria that she absolutely had my support to do the right thing as a Medical Director and would only

expect that to be the case.

177 Q. The description that Dr. O'Kane has provided might be regarded as a somewhat extraordinary intervention on the part of the Chair of a Trust, knowing that there was a process in train, MHPS, knowing that that hadn't concluded, knowing that Dr. O'Kane had her hands on the levers of power in that context. Did you take this up with the Chair?

A. No. I gave Maria my full support that if she needed to pursue safety and quality issues she had my support to do so. I did not take it up with the Chair.

178 Q. Assuming it to be true, as I think you might have, was there any other action you could or should have taken vis-à-vis the Chair?

A. I could have discussed it with the Chair, but at that point I did not feel that I could discuss it with the Chair.

179 Q. If the Chair was behaving in this way by flexing her muscles and creating what Dr. O'Kane has described as chill factor, on the face of it that would appear to be contravention of, for example, the Nolan Principles, that's now Trust chairs presumably shouldn't be using their influence to assist theirs friends in matters of professional conduct proceedings?

A. That is correct, yes.

180 Q. Is this not a matter, if it happened in the way that you and Dr. O'Kane describes, that should have been raised with the Department and left for them to address with the Chair?

obtain permanent change, that this was typical of that, another false dawn?

A. Yes. Absolutely.

296 Q. Was there any sense that you were aware of people -- and here I mean Mrs. Gishkori, Mr. McAllister, Mr. Weir -- running scared of Mr. O'Brien for any reason? 14:46

A. No. Well, taking them individually, certainly not Charlie. Dr. McAllister, I would have held him in high regard in terms of his ability and his role as an AMD and I would have been under no illusion that he would have been willing to address any issue with any clinician if it was required of him. I think, from Colin's evidence yesterday, I think Colin maybe did have a bit reticence in tackling Aidan and Esther. I don't know about Esther. 14:47 14:47

297 Q. Was Mr. O'Brien seen to be closely connected with the hierarchy within the Trust?

A. Everybody knew he had a close relationship with Roberta Brownlee, yes. 14:47

298 Q. But you don't know whether this was a factor in the behaviour in September or October, to depart from Oversight?

A. It certainly wouldn't have affected Charlie, that's for certain. I doubt it would have affected Colin. Whether it affected Esther, I would be less certain. 14:48

299 Q. Why do you say you'd be less certain in her case?

A. Roberta kind of directly appointed her.

300 Q. You say in your statement, when reflecting on these

his dealings with others; so much so that I believe that others (including myself) didn't challenge him enough because, when we did, he always challenged back and he wore people down to the extent that, in my opinion, he was able to continue to do his own thing (whether that was the correct way to do things or not). Mr O'Brien's response to me on numerous of occasions was, 'are you, as a non-clinical person, questioning my decisions?'. Examples of when he would have said this would have been when he was admitting patients straight from home a few days before they were going to theatre for work-up and the hospital system was struggling with bed pressures and trying to get the emergency department freed up to see other patients. When I took advice from other clinicians on this issue (as I always did first), they would have told me there was no need for them to be admitted so early in advance of their surgery and they would have detailed what needed to be done and what could be done in the community or via a visit to hospital outpatients in advance of being admitted. I always would have advised Mr O'Brien of this but he would then get cross, as he considered that I was going 'behind his back', and maintain that what the others were saying was incorrect.

67.3 From other consultants, I have heard some of them saying that Mr O'Brien was their mentor, either during training or when they came to work in Craigavon Area Hospital, and therefore I believe this made it more difficult for his colleagues to challenge his practice as they respected him too much.

67.4 Urology are a close-knit team with the majority of the team having been together for a long number of years and I think Mr O'Brien's practice became accepted, that there was a view that, when issues have been raised, nothing was done to him, and that people (including myself) became complacent. People would have said, 'it is just Aidan and, sure, that is the way he has done things for years'.

67.5 It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr O'Brien's practices and Mr O'Brien

using his connection to the Chair to his advantage, were other features or causes of what went wrong within Urology services. On occasions, Mr O'Brien in conversations with me and other members of the team would advise that he had spoken with the Chair directly to advise her of the capacity issues within Urology Services and he would have told us that she had assured him that she would sort this out, for example, that she would work on getting the urologists more theatre time. He would have advised of the times that he had met and spoken with Mrs Brownlee at social functions and that he had made her fully aware of what was happening in Urology. He also mentioned on a number of occasions that she was involved and supported the work of CURE (Craigavon Urological Research and Education), which is a limited company set up by a number of urological staff to provide funding (raised through fundraising) to allow for urology staff to do research and training and attend courses, and of which Mrs Brownlee had been a Director and she had also been actively involved in fund raising. As previously mentioned, I believe she was involved in asking at least two members of Trust staff who were actively trying to manage and address concerns regarding Mr O'Brien to step back (Mr Mackle and Mrs Gishkori). Although I am not aware of any other incidents, this outside influence always concerned me because, like the mentioning of his legal connections, Mr O'Brien also referenced this connection in his conversations and, in my opinion, the purpose may have been to make others feel intimidated by the knowledge that he was influential with someone who held a senior position in the Trust's senior management.

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

68.1 In my opinion, there has been a lot of learning from a governance perspective and in this paragraph of my answer I confirm that I would agree

14 September 2018

FILE REFERENCE: 14

AIDAN O'BRIEN
(DR WRIGHT AND MRS Personal Information redacted by the USI **O'BRIEN)**

Audio Transcription Prepared by:

Angela Harte
Personal Information redacted by the USI

DR WRIGHT: Thanks for coming.

MRS O'BRIEN: I don't think you'll be thanking me --

DR WRIGHT: Well --

MRS O'BRIEN: -- for coming in, however. Right. Is this the same room where it all happened on 30 December 2016?

DR WRIGHT: This is the same room.

MRS O'BRIEN: The same room.

DR WRIGHT: Right.

MRS O'BRIEN: Right. Well, let's start with 30 December. I'm here today because of me not because of Aidan. I'm what you might call collateral damage out of this which obviously doesn't come into the thinking of someone like you who imposes it but that's the reality of it. And very kindly now Shane -- I came here three weeks ago, I think it was on your last day. I had phoned up to make an appointment with you but it was your last day. So I came down in the hope that I would have seen you.

DR WRIGHT: I apologise, ~~(Inaudible)~~ I didn't know until I actually got a phone call. I was (inaudible).

MRS O'BRIEN: Well, anyway, Shane was very nice. I have met Shane on one other occasion socially. I must say I am very impressed with him, even having only met him twice. He was very kind and he said that he certainly would get in touch with you. I was very emotional that day. Very, very upset.

So what I want to say to you today is that what you did was a grave injustice. Grave injustice. And I want to ask you, on 30 December did you know why Aidan was on sick leave?

DR WRIGHT: I did.

MRS O'BRIEN: Did you know the --

DR WRIGHT: I didn't know the details of it.

MRS O'BRIEN: Didn't know the details. So you wouldn't have known, for instance, whether his prostatic biopsies were positive or negative?

DR WRIGHT: No.

MRS O'BRIEN: No. You know, I just think it's incredible that the haste with what happened in the run-up between Aidan leaving to go on sick leave and then on 30 December there was such a haste in gathering information, which I will show you now was incorrect.

DR WRIGHT: Mmm.

MRS O'BRIEN: Which never was checked with him. And this was compiled. There was haste. There was oversight committees set up. That was all decided. And I think on that

last week, that week running into 30 December, which was a Friday, Aidan had been feeling a good bit better and was doing -- coming into the hospital on his sick leave and he was doing work and he got a phone call. Now, I can't recall was it to his mobile, I think it was to his mobile, asking could he come to meet with you the following Tuesday I think it was. And Aidan said, no, he couldn't meet with you because he had scheduled day surgery that day. But he said could arrange some other day. So it was arranged then. He said I am off, I'm on sick leave this week, but I am in and out doing things, preparing things for next week. I could meet on the Friday. I think you were on annual leave. So you met on the Friday.

Now he rang me and said I got a call from the medical director's office that they want to meet with me to discuss some things. I said what is it about? And he says I don't know. And I said, well, ring back down and ask for an agenda. So a very brief agenda was sent up to him and it says, "you may be accompanied by someone".

Now, only I had asked him to ring back down to get an agenda to see what it was about, he would have gone along there on the Friday, if he hadn't mentioned it to me, and he would have had to be faced with that absolutely catastrophic decision without being spoken to beforehand about it. Anything like that. It was just shabby. I am glad I was there with him so that I could drive him home.

I can tell you now it will say in all those booklets, but I don't think yous take it on board, the stress and mental anxiety that it causes. Now Aidan was in complete meltdown. Complete meltdown. I was trying my best to support him. Being given document -- never having heard of what a formal investigation's about. This was a consultant who was here 24 and a half years. And, Richard, you were here a year and a half. Had you ever met Aidan before it?

DR WRIGHT: Yes I had met Aidan before. ~~(inaudible).~~

MRS O'BRIEN: Once. I think in the April he said. So I just -- it just came -- it was just incredible. Just incredible. Now I am past, ~~(inaudible)~~ to make matters worse it wasn't the unjust nature of it, it's now the way that this is compounded by the way this investigation has taken place. And there is nobody -- I have read every document there is. I have read the MHPS, the guidelines, NCAS. And do you know what the overriding thing that comes out to me in all of those documents is, this is the last resort for an investigation. You must try other means in an informal approach because most problems can be sorted out in an informal approach. But that wasn't done.

DR WRIGHT: Well, I suppose I will have to respond to that in that we did meet with Aidan to try and resolve some of the issues.

MRS O'BRIEN: We'll just deal with that then. 30 March.

DR WRIGHT: Now, maybe they could have been done better but.

MRS O'BRIEN: No.

DR WRIGHT: Probably --

MRS O'BRIEN: Now, I have read all the witness statements and everything now.

DR WRIGHT: I should say, I haven't seen the report.

MRS O'BRIEN: That is okay.

DR WRIGHT: (Inaudible).

MRS O'BRIEN: It's not done. It's not finished. We're still in it. It's 20 months later. 21 months now.

Heather Trouton I think came to you in January of 16. You were here six months at that time. And she must have informed you of ongoing back logs and a back log of triages (inaudible). And she seems to imply in her statement that you advised her how to -- that to approach Aidan about it. So I don't know whether you advised her on a particular route or you just generally gave her the go ahead to, yes, bring it up. But how would you have expected her and Eamon Mackle~~McIll~~ to deal with that as an informal approach?

DR WRIGHT: I would have hoped they would have met with Aidan.

MRS O'BRIEN: And what?

DR WRIGHT: And discussed what the matters are and how they were going to be resolved.

MRS O'BRIEN: Yes. You would have thought that wouldn't you. What happened was, ~~when~~ well Heather wasn't there, it was Martina Corrigan and Eamon Mackle~~cIll~~, so they met with Aidan, I think about a few days after, and they presented the letter to him. Eamon presented the letter to him. He said, Aidan, you know we have these few things. You know. These things we need these attended to. And Aidan said and what am I to do about this? How am I to do this? And you know what Eamon Mackle~~cIll~~ did?

DR WRIGHT: No.

MRS O'BRIEN: This is what he did.

DR WRIGHT: Right.

MRS O'BRIEN: That is what he did and that is the truth. Now, I am not lying or saying anything here. This is all truthful. This is all the truth. And that is what Eamon Mackle~~cIll~~ did.

DR WRIGHT: Right.

MRS O'BRIEN: He did that. What should have happened, in my opinion, then was, look, you have a back log here. Now Aidan's there 24 and a half years, 24 years at that time, but I mean no one had ever come to harm at the hands of Aidan. I think what we should do

here, Aidan, is, you know, I think we'll reschedule your work for a few weeks so that you can focus more on this back log and we'll get it done. A couple of weeks would have done. That's what would have done it. End of story. But no.

You, on 30 December, the thing escalated again. As you said, due to it had come to your attention about a SAI which hadn't been completed. When we were in this office I asked you, Richard, was this a patient of ~~yours~~ Aidan's? You said yes. It wasn't a patient of Aidan's. It was a triage letter.

So, you know, then it come along and this -- you know -- you see, well, anyway. I am just going to show you some other the things that (inaudible).

So these are the three things. I thought this was quite interesting. I had lost or couldn't put my hand to it. I think my son has it. But I see they have been updated. And in flicking through it there's one essential major change has been made in this one. On the original one it says that the investigation must -- and it highlighted it and it had -- it was in italics -- must be completed within 12 weeks. There is no exception in this for going over four weeks.

In relation to hospital -- where does this document -- what is this document, why is it there, as opposed to just having that one?

DR WRIGHT: There would be some -- we would often have -- so, for instance, most guidelines and most standards that would come from central source you would adopt or add to or change. So we would have lots of ones that would come from NICE and different organisation where we would modify them so we can comply with them and then they become our own ones. So because there are some ones that we can't comply with. We would have to change them and say we couldn't do them. So it would be normal procedure to have your own version but they are actually ~~(inaudible)~~ based largely on the existing one.

MRS O'BRIEN: So which one applies?

DR WRIGHT: Well, the Trust one is the one that from October 2017.

MRS O'BRIEN: The one that you have given us last year was 2010.

DR WRIGHT: Right.

MRS O'BRIEN: September 2010.

DR WRIGHT: That's right. So it came to light (inaudible) but it was based largely on this .~~(inaudible).~~ So reading (inaudible).

MRS O'BRIEN: It's very strict. It's very -- the protocol. Now I'll just show you something. You're talking about a doctor here of 24 and a half years. Someone that, in my opinion and in the most people's opinion, is unsurpassed in his care of patients, his integrity, his

honesty in his acknowledgment of any failings he might have. There is no one. No one.

I never used to keep these. I keep them now because of appraisals and things but these are all the things that patients would send to Aidan. I am just going to read out a few of these things to you:

"Aidan, I would like to thank you for everything you did for me this year. Your care and compassion and actions have changed my life this year and really my whole family's lives. Some people go through life and very rarely never contribute. But, on the other hand, there are a few like yourself who touch people, who touch people's lives and make them so much better. I hope that you continue to be a beacon for health care for many years to come. God bless. Personal Information redacted by the USI."

DR WRIGHT: That is lovely, it's lovely. ~~(Inaudible).~~

MRS O'BRIEN: This other one:

"Dear Mr O'Brien, we would like to express our gratitude to you for this time for your time, your care, your expertise during Personal Information redacted by's illness. We first met you over four years ago at the beginning of Personal Information redacted by's cancer diagnosis. From that first encounter we felt confident and reassured of your professional approach. We are eternally grateful for all the attention, the treatments and care Personal Information redacted by received while he attended Craigavon. We are so thankful for the three years of quality living and the one year of reasonable health that Personal Information redacted by was afforded following his illness. This allowed him time to live life in the most fulfilling way possible. We know that you did all you could for Personal Information redacted by and we will always be appreciative of your unfailing dedication. We would also like to thank you in a special way for visiting our family home. It was very kind of you. We will keep in our thought and prayers."

DR WRIGHT: ~~(Inaudible)~~I mean, he is clearly a very highly regarded clinician. It is lovely to have those letters.

MRS O'BRIEN: And then, "It was with deep regret" -- I picked out a few of these because they are very poignant because it shows -- it's not just "thank you". These were people who took the time to talk about those extra things. So:

"It was with deep regret that we want to let you know the recent and sudden death of our mother Personal Information redacted by. Heart-broken as we are, we realise we have so much to be thankful for and a big part of that thanks is due to you. Thank you for her last 12 years of quality life which our mother always acknowledged was down to you and your skill as a surgeon. We used to joke with her on the many review visits at your clinic because she always wanted to look her best but she saw this as a tribute to you. She wanted to show you that the surgery you carried out on someone in their 80s had been worthwhile, something she

appreciated every day."

Because, believe it or not, there's an awful lot of ageism in medicine nowadays~~(inaudible).~~

DR WRIGHT: I know, I know ~~(Inaudible).~~

MRS O'BRIEN: And Aidan has never applied that. Now this one is quite interesting because this is from another healthcare professional outside this Trust:

"Dear Mr O'Brien, I didn't want to waste any time in dropping you a line to thank you most sincerely for the care you have provided to my father [Personal Information redacted by the USI]. As dad will confirm, I am not often lost for words. He and I often find ourselves locked in debates. I am struggling however to convey the magnitude of how grateful our whole family are for everything you and your team have done for him to date. I know that dad was resigned to urostomy but dad in reality was pretty devastated at the thought of having a second bag. It goes without saying, therefore, that he and the rest of the family are so totally thrilled at the chance you have given him at some sort of normality. Not only are we indebted to your surgical skills but I know that dad and especially mum are so appreciative of the human aspect that you have brought to dad's care. The acknowledgement and the understanding of the rough few years that he has and the uphill battle to get someone to take him seriously has meant a great deal to them both."

Now, Aidan gets a lot of these patients who are sent from pillar to post, can't do anything, can't do anything. Aidan always tries to explore every avenue and to do something. In this case -- this is one of these cases.

"Thank you as well for your patience and the time you took in explaining dad's surgery and the options to him a few week back. I work in [Personal Information redacted by the USI] and in my case it was certainly a case of a little knowledge being dangerous. With dad's track record and poor luck, I had visions of him septic, ventilated, critical illness, neuropathy, the works. Naturally in this case I am delighted to be proven wrong. I know that it is still early in his recovery but in comparison to previous surgeries we are all so pleased with his progress. Thank you from the bottom our hearts. With heart-felt gratitude."

I mean, these go on and on and on. I think this one is quite good here.

DR WRIGHT: Okay.

MRS O'BRIEN: Because Aidan was 65 in July and this patient sent him a birthday card and she said:

"I am so sorry I missed your big birthday but this card is sent better late than never. You have given me the very best treatment over the years and you will always be more to me than my consultant. You know I am selfish when I say I don't want you to retire but I

think it is time you slowed down and give Mrs O'Brien a wee bit more of your time. No other woman would put up with the amount of hours you work. I will be really sorry to see you go but it is time to slow down."

I just -- it is -- to have this happen to Aidan is just -- it's the most unjust thing that has ever happened. There was no care. There was no thought given out. Let us -- didn't you say to -- out of interest, did Ronan Carroll come to you directly or did he go -- or it did it come -- did he go through Simon and then to you with the complaint?

DR WRIGHT: I truthfully ~~just~~ can't really recall how that started. So it will either be -- ~~(Inaudible).~~

MRS O'BRIEN: Ronan Carroll -- there was a changeover in the March.

DR WRIGHT: There were a lot of changeovers (inaudible).

MRS O'BRIEN: In April there was a big change.

DR WRIGHT: (Inaudible).

MRS O'BRIEN: So the big change happened in April. Ronan Carroll came in to --

DR WRIGHT: There was a new director as well. Obviously Esther had started some time before that.

MRS O'BRIEN: And then --

DR WRIGHT: And then in the middle of it all Eamon of course stepped down.

MRS O'BRIEN: Eamon stepped down from that. So anyway, Colin Weir stepped in as the clinical manager and Ronan was the assistant director, I think was his title. So this was brought to their attention in the handover and they discussed it. And I think Charlie and Colin said, well, you know -- Charlie said we'll have to speak to Aidan. We'll have to try and help Aidan. Aidan is a really good doctor. You know. And Ronan Carroll -- so Colin said yes. We'll speak to Aidan. And he said no, no, don't speak to him. Martina and I will speak to him. He was told not to speak to Aidan. And then Colin in his statement he said that a few months later he enquired of Ronan, well, Ronan, what's happening now? Have you talked to Aidan? He said no, I've sent it to the medical directors.

That's another one. Here's another one:

"I am writing to convey my sincere thanks for the relief you brought into my life after years of living in fear, not able to travel in comfort and about my day to day duties with hesitation moving around. Fear has been moved out. Again, may I reiterate my sincere thanks to you and your team and your surgical skills be forever blessed with success as I have been."

Can you tell me why none of this was taken into consideration?

DR WRIGHT: Well, I am sure (inaudible). I mean, first of all, we launched an investigation.

We haven't got an outcome from it yet. I am as frustrated as you that it has taken so long, although what I would say is, despite what the MHPS says, they nearly always do take a long time to do them properly. That's one of the difficulties with the whole MHPS process.

MRS O'BRIEN: You see that's where I disagree with you because in those documents what happened -- what is supposed to happen is that people are given time to do it.

DR WRIGHT: One of the difficulties -- well, that's right and that is --

MRS O'BRIEN: That is the fault of it. If people were saying, you have to do this investigation, it will remove you from your post for a month, it will be done.

DR WRIGHT: I sort of agree with you on that actually and that's been -- we tried -- or we have been trying to change the way we do these for some time. We even got to the stage where we had completely as a region redrafted that whole MHPS process because I believe it was acknowledging that these things were taking too long. So, I mean, I don't think I can argue with you on that. We thought we had a better system almost across the bar at departmental level and it never quite got changed. There was a change of minister and different things happened and obviously with what's happening now (inaudible). So we didn't manage to get the MHPS process changed. We're stuck with that. There is an acknowledgement I think between all the medical directors in the province that the current investigation system is too slow.

MRS O'BRIEN: Can I suggest why?

DR WRIGHT: And part of the reason you have said because of time.

MRS O'BRIEN: No, no. It's because, when I look at these documents, the things coming out (inaudible), in what circumstances do you hold a formal investigation? And me it's coming out loud and clear, particularly because they mention occupational health a lot, I would imagine it's a doctor who has a drug problem, a drink problem, there has been a sexual assault.

DR WRIGHT: It can be that.

MRS O'BRIEN: There's been theft, drug abuse, something like that. But do you see the problems that were in relation to Aidan, all that took, all that needed was, let that man have time to do that back log. That was all.

DR WRIGHT: And that might be. That could be. It might turn out to be the case. If that is what their conclusions are. But it might not be conclusion of the all whole thing at the end of the day I suppose but you don't know that until you have looked at the problem in depth. This was an issue that had been -- obviously brought to my attention. Once it is brought to my attention, I can't -- I actually can't do anything informal in that way about it. I have to

(inaudible).

MRS O'BRIEN: Richard, no, no, no.

DR WRIGHT: We have an informal --

MRS O'BRIEN: You can't say that.

DR WRIGHT: We have an informal investigation (inaudible).

MRS O'BRIEN: Sure, that MHPS is -- there is an informal approach.

DR WRIGHT: That's right. That's right. So we did do that.

MRS O'BRIEN: No, no. You told us at the time, you told Aidan in the letter at the time, when Aidan said why was the informal approach not used, and you said --

DR WRIGHT: Because there was sufficient concern at that point that we had to -- we knew there had been (inaudible) triage.

MRS O'BRIEN: With no remedial or supportive action.

DR WRIGHT: Well, that wasn't entirely clear at the time.

MRS O'BRIEN: All it needed was ask the question.

DR WRIGHT: Well, the questions were being asked and we were getting different answers. I suppose that's -- so, I mean, that's why we have to get on top of it. It was a serious enough issue that was raised. I am genuinely sorry it has taken so long to bring to conclusion. It was an investigation that could well have -- I mean, it may well still, end up saying that the departmental management was not on top of this problem. There wasn't support there. I am sure those all those things will come out. I don't know if there will be any criticism of Aidan or not that. That all remains to be seen. It is a great regret that it has taken so long to get to this stage. However it is hoped that that would have been ~~(inaudible)~~ sorted out.

MRS O'BRIEN: What is the average time for them?

DR WRIGHT: Well, Maintaining Higher Professional -- it wouldn't be -- it would be rare to get them completed within six months. It wouldn't be that unusual for it to go on well past a year. On occasions in the last several years that has been my experience to date.

MRS O'BRIEN: Right, well, so the subject matters you see now. Ronan Carroll came -- I have great -- I have -- I could work this all out. When I heard the names, I mean you saw my reaction that day when I saw that letter --

DR WRIGHT: I did actually yes. ~~(Inaudible).~~ Yes.

MRS O'BRIEN: -- and Eamon Mackle~~McIll~~. Now, it's quite clear in all the statements, I don't know who has put out this and it's probably Eamon himself who peddled it around, that Aidan had submitted a grievance about bullying years ago. Absolute lie ~~(inaudible).~~ I mean, I have the letter here that Aidan sent to Gillian Rankin, the grievance that he put

in, because Aidan -- they had asked the consultants to do extra contractual work because there was back logs and things to be done and there was -- and Aidan had put in his expense form and he's very slow -- I'll tell you something. Aidan hasn't claimed -- he doesn't have time to do anything else only up there. He hasn't claimed travelling expenses in 12 years. In 12 years. The last thing on his mind. He goes to Enniskillen. He went to Banbridge. All those. He hasn't claimed anything.

So this probably, when he put in this claim for that, it might have been a few months later or something. And he never -- Aidan never looks at a pay check. He always relies on me to keep on top of everything. So he just happened to say to me, did that payment come through and I said, yeah, it did. It was £Personal Information redacted or something. He says £Personal Information redacted? I swear I put far more in than that. So when he looked at it, yeah, he thought that's -- he checked and he said that should have been £Personal Information redacted he said.

So he rang up the payroll and he asked -- he said, you know, I think there's a mistake there, what was all put in. She said I'll go and check. So she got all the expenses forms back and Eamon Mackle~~cIll~~ had scored out everything and halved it. The girl didn't know it was. She said there's been things scored out here and it has a signature on it. And Aidan said could you send me copies of them. It was Eamon. He had done it.

DR WRIGHT: Okay.

MRS O'BRIEN: So Aidan had to send in a grievance to Gillian Rankin about it. This is just one of the things. Eamon just never liked Aidan and he did this. So when that went in and then, you know what, everybody will say there's no record of this in but I have it. I have it there. So they agreed that what happened was wrong, whatever. And they asked Aidan did he want to take it further in a formal grievance. At that time Eamon's Personal Information redacted by the USI and Aidan said no, I'll leave for the minute but if anything ever~~y~~ happens again I will resurrect it. But this has now gone round all the management. So many people in their statements said, well, I know now that Mr O'Brien had complained about Mr Mackle~~cIll~~ bullying him. Common knowledge around them all. It's amazing. It never happened. It never happened. And that's just hearsay or whatever. I don't know.

But anyway with regards to the things -- the only figures that I can't quantify~~ty~~ are the figures of triage that Ronan Carroll submitted to you. Now he submitted to you. He said there were 60 -- over 60 clinics with 668 patients that were not dictated. And when Aidan was eventually provided with -- what this list was, that's the list that was presented to him.

DR WRIGHT: Right.

MRS O'BRIEN: And there are 61 clinics on that with nothing. And then because I had all -- because he had the charts at home and he was working on them and he'd done most

of them, this is what the list should have looked like. This is about checking figures checking facts before. Just not taking it for granted that if somebody is giving you these, they're right. Have you double-checked them? Are you sure? That's what should have at.

So all these things in blue they were all completed. That means returned, outcomes done, dictation done, everything. All of these in blue. So there was 41 clinics, not 61, and it included -- so. The number that wasn't processed was 189. Not 668 like he said.

And even alone, believe it or not, when Aidan got the -- Dr Chada's folder, when it had gone to the manager to -- for -- and Aidan gets to see it to check anything. This here actually wasn't in her folder even though this was what was given to Aidan. She hadn't put this in as an appendix. And she hadn't put that in that Aidan had given her. The only thing I can't quantify is the triage. They got these numbers wrong. I don't know. The triage.

There was this thing about the private patients that came into it afterwards. It was very insulting, very demeaning. And they said they reviewed the TURP~~urp~~ patients in 2016. And Aidan had done 46 TURP~~urp~~s in 2016 among other things. And out of those 46 there were nine who had come to see him at some time privately and these were picked out as shorter waiting times. But, I mean, these are picked out by managers. Managers just don't seem to grasp waiting times, you know, I think. I think they imagine that when a surgeon is picking his operating list, right, I'll get my list and I'll go to the very back and I take the ones from the very back and I do them. That's not the way it works with Aidan anyway. It's clinical priority. It's always based clinical priority. Because you could have some man waiting three years for a TURP~~urp~~ who's getting up twice at night. It's not a huge bother to him. But you could have someone who is on the waiting list six months and he's getting up six times a night. H~~h~~is quality of life is gone. He can't operate. He can't function properly. So he identified that there was nine. That's just because there was nine that had a private letter on the thing.

So the ~~main~~ mean-waiting -- Aidan did a -- he went through all his 46 TURP~~urp~~s and the mean waiting time for the nine TURP~~urp~~ patients, who had come at one time privately, was 202 days and the mean waiting time for the remaining 37 was 219. So where is the difference? There was no difference.

But, interestingly, that nine TURP~~urp~~ patients, you mentioned it in your letter, everybody mentioned it in their letters and in minutes, whatever. And then on the August, when Aidan goes for his first interview with the investigator, he asked about the private patients. And they had just got an email through that morning. So there was no identification on the list. There was just the list and the hospital numbers and whatever. And it had just come through to them that morning. So Aidan said my goodness. In fact

there was 11 on that.

So when he brought it home that afternoon Aidan would have always kept a record of hospital numbers of patients and he was very exhausted that afternoon coming back from that meeting. He handed me the list and I went into the diary and I looked at the hospital numbers. The first hospital number I came across was a young girl that I know very well, who's Personal Information redacted by the USI who had come to see Aidan which ~~(inaudible)~~ it wasn't fee paying, as a matter of courtesy. I said this isn't a TURP~~urp~~. So it turns out, when we looked through them all, there were three TURP~~urp~~s on it. Three TURP~~urp~~s.

Now, I would be quite suspect that when he really did look at the nine TURP~~urp~~s they didn't quite fit the criteria As y~~Y~~ou can see. So, I am going to have to look at other things. So he -- there were things like diagnostic procedures, like a cystoscopy, like a flexible cystoscopy, like day surgery case. So they could only -- ~~(inaudible).~~ So Aidan hasn't had time to do a comparison. But as Aidan -- as he said, you know, when you come up with a -- where is the comparison with the NHS patients? I mean, a manager can look at lengths of time on a waiting list. The manager has no clinical knowledge about priority, clinical priority. But again, Richard, you accepted that.

DR WRIGHT: It was a concern that was raised at the time. I accepted that we needed to investigate it.

MRS O'BRIEN: You see, the interesting thing is, you know --

DR WRIGHT: I certainly haven't jumped into or taken any ~~(inaudible)~~ conclusions but I suppose that's the point. There were concerns raised which, on the face of them, were reasonably significant. So, you have to chase them out. It may well turn out that they are not. They are unfounded. And (inaudible).

MRS O'BRIEN: It may well. I am telling you they are unfounded. I am giving you the reasons.

DR WRIGHT: I would be delighted if that was the case. Delighted. But given what was presented to me, I suppose I could not not have investigated.

MRS O'BRIEN: I think my main problem with you, Richard, would be there was no need to investigate it. All that needed to be done was, you should have, on that 30 December or on the following week, you should have met with Aidan. You should have said, Aidan -- because that's what it says in here that you're to do. The practitioner is supposed to be involved right from the start. Before the investigation starts. Before oversight. Whatever. Unless it is something like is this consultant going in drunk. He can't operate. Is there a clinical incompetence here. You know, real serious stuff. Aidan could have told you there and then. He could have said, yes, I have a back log but do see those 189 that

are not done, they are very low grade. There's -- everything important, everything that's critical has been done. These are people who are going to be maybe waiting for 18 months for a further review or something. They're non-urgent. They're low grade. You know, that was all that had to be done. That was all that had to be spoken about. There didn't seem to be -- there didn't seemome to be the will from anyone to explore that, to let's be supportive. That -- in December you could have said, do you know something, you are just coming back from surgery. Why not take a month and do all this work the next month and we'll get all these things back. Problem solved.

Do you know that -- do you see all those charts that were returned and they came back. Aidan has compiled complied with everything he has been asked. And they came back on 3 January. And I don't know what they did. They must have just checked numbers and patients against a list of whatever. And then they were put up into an AMD office in the main building.

DR WRIGHT: Mmm.

MRS O'BRIEN: And do you know that Aidan was in that office with a meeting with Martina and Colin and Ronan about -- I think it was about emergency theatre lists or something. That was six months later. Do you know that they were all still sitting there? They were all still sitting there. Not one of those things, not one of those outcomes had been enforced, had been recorded. Nothing. Aidan looked around and he said are they are still here? He couldn't believe it.

And when we were in the December and Aidan was so concerned about the patients that he had scheduled for January and people he had wanted to see at his Enniskillen clinic and the people who had done(inaudible) surgery, and you said that day -- and Aidan said what will happen to those? You said, well, I'll take responsibility for those. No one took responsibility for them. And in fact one of the people, Aidan just told me the other day he's concerned about, one of the people he had on his list to be seen at Enniskillen in January was a man who had a rising PSA. That man should have been seen in January. And do you know when that man was seen? Just last month. That clinic hadn't been reset the way it was. Now that man's PSA has quadrupled. So Aidan, he says now, the MRI is not showing anything but to be sure I have to biopsy him. So if he's biopsy-ed now and there's a cancer and that delay has happened, who is going to be responsible for that? And will Aidan have to put in a SAI about that?

DR WRIGHT: Well, to be fair to Aidan I would have thought, if that does happen, he totally should raise it as an incident.

MRS O'BRIEN: But you said you'd take responsibility for that.

DR WRIGHT: I suppose I will. It comes with the turf.

MRS O'BRIEN: Because the SAI that you told me was one of Aidan's patients, which it wasn't, the SAI, I am sure you saw the report of it afterwards, because that lady she was referred with a simple cyst that was on her kidney. That had been on. And she was having pain in her side, which can happen with a large simple cyst. But what was not reported on was that in MRIs or a CT scans of earlier (inaudible) the radiologist had missed another shadow on the kidney and it hadn't been reported on. That lady would have been seen multiple times because she had breast cancer. Multiple times with breast surgeons, with general surgeons, she had bowel cancer as well, and oncologists. And no one had picked it up.

And yet Mark Haynes picked it up when he first saw her because that was one of the ones that hadn't been triaged. Now, Mark Hayes was quite candid -- was very truthful with the patient and said, you know, your doctor quite rightly has sent in this appointment about your cyst and it is routine, a simple cyst is routine, but I have noticed looking on previous scans that there's a wee suspect thing here. So that was in January 16. And yet there seemed to be such focus put on the clinician who missed it on a triage, you know.

I mean, Aidan has -- and when Aidan did his report in response to that SAI, the thing he said and the recommendations he were made was that there has to be time allocated to triage because if you get 120 triage a week, and Aidan is very opposed to the -- he had told them -- I mean, he had told them a number -- he had been telling management all along that it was impossible to do triage when you're urologist of the week because you have such ill patients. you have ward rounds, you are taking them to surgery. Whatever. There is no time. That's why he didn't do the routine. He always did the red flags. He just didn't have the time. He told them that. And his recommendation at SAI was that there has to be an urgent look at allocation of time to do triaging. That was in March 16 it's now September 18. Nothing has been done. Nothing has been done. No one is interested in taking it on board.

And as a result of -- Aidan has come back to work and he obviously does the triage now and you say to yourself, how can he do triage now when he didn't. But Aidan takes -- his week on call would be from a Thursday morning to a Thursday morning and he takes the Friday off as annual leave to do the triaging because that's what it takes. It takes a whole day to do them. Because of the waiting lists that there are you just can't ignore some of the triaging that's coming in and leave them if they are urgent because they are going to have to wait over 52 weeks for an urgent and a routine is going to take 80 weeks.

DR WRIGHT: I know. (Inaudible).

MRS O'BRIEN: So therefore you have to be a bit more pro-active. Now, if you were to spend five, ten or 15 minutes because by the time you look up things, look up images, I mean, the likes of that SAI case, the lady, that would have taken 15 minutes to do. So if you add up 15minutes, you're only getting four done in an hour. Where's the time coming out of for it? There's no time in their job plan to do it.

DR WRIGHT: There certainly should be adequate time. I suppose how much time you need is something the urology team would need to decide between them what the right (inaudible).

MRS O'BRIEN: This is it. They won't do it. They're having an away day now next month and Aidan said he -- what he wants is he wants that they will all agree what form of triage to take place and to quantify it and to leave time for it.

Now, they would have asked him during the investigation, well, how is it others did it and you couldn't do it? And Aidan knows why other could do because others would leave things to the registrar to do. Aidan wouldn't --

DR WRIGHT: Right, okay.

MRS O'BRIEN: -- let the registrar do that.

DR WRIGHT: (Inaudible~~)~~ they do need substantially more time and that may be (inaudible).

MRS O'BRIEN: I think Mark Haynes has already -- he reckons there should be six hours' time on it.

DR WRIGHT: Yes.

MRS O'BRIEN: But this is the NCAS. Now, that's the other thing when you talk about it. It says:

"Terms of reference have to be based on and have to be set up at the time the investigation is set up."

There was no terms of reference on 30 December. He got terms of reference in March. No terms of reference had been done. It says:

"The decision to investigate~~s~~ commits the organisation to significant work and expense so the organisation needs to be sure -- needs to be sure -- that the concern is serious enough to warrant an investigation based on the available information."

That would have been my main criticism of it. The information was not double-checked and the best person to have checked it with was Aidan and that wasn't afforded to him.

It seems to be that the whole thing just -- like nothing, Richard, nothing in any of those documents was followed. Protocol wasn't followed. It just wasn't followed.

For instance, Aidan has asked no number of times for the notes of the minutes of your

oversight group, of your talks with NCAS. Nothing. I mean, did you speak by telephone to NCAS?

DR WRIGHT: NCAS there were -- there were no formal meetings. I spoke on the telephone to an NCAS Advisor~~y~~ about the case as I recall.

MRS O'BRIEN: It says that, you know, when you are speaking to NCAS that you speak to them when you are going to consider exclusion. You had already decided you were going to exclude. The reason that you talk to NCAS is so that they can look at it from another perspective and to explore the alternatives to exclusion. You see the exclusion, Richard, was the most hurtful. The most hurtful part of it.

DR WRIGHT: I can explain why, you may not agree with it, but why we took that. First of all, you say that -- it a very unusual set of circumstances and that Aidan had been off on Personal Information leave. So normally you would have had -- the person would be there and you had opportunity to (inaudible). So he was coming back from Personal Information leave so that did make it -- ~~(inaudible)~~ it and then the timing of that concern ~~(inaudible)~~ was brought was around that time, ~~(inaudible)~~ but it all happened around about that time. So things were a little unusual. We were then made aware that Aidan was coming into do some work on site which, to be honest, he shouldn't have been doing. So that was --

MRS O'BRIEN: No one -- in fact Aidan -- it was news to Aidan that when you're off more than six weeks you have to see an occupation health. Aidan's never been Personal Information redacted by .

DR WRIGHT: Yes, I appreciate that, and doctors are notoriously bad, but the thing is when you are off Personal Information you shouldn't be in work. And I think that -- ~~(Inaudible).~~ So that complicated things further.

We're at this time considering the information that was coming to us, whether we needed to move with a formal investigation and what we would need to do. We were~~'re~~ trying to get at much information as we could. And my main concern, although you may not --

MRS O'BRIEN: I know what your main concern was: the missing charts. Because you said in that meeting that you were going to have to report to the chief medical officer on the Tuesday that the notes were in the Trust ~~(inaudible).~~

DR WRIGHT: We couldn't find them. (inaudible) potentially a very serious thing ~~(inaudible).~~ So the main concern, the reason for the exclusion, now exclusion is not meant to be a punishment.

MRS O'BRIEN: But it was. (Inaudible). It's not meant to be but that is the consequence of it.

DR WRIGHT: I accept that that was the way it was taken ~~(inaudible)~~ but it wasn't intentional for it be to be the case~~(inaudible~~).

I didn't want any allegation coming in at a later date that Aidan had been in work in the office and they couldn't -- until we knew how serious the problem was, I didn't want any allegation coming forward that Aidan in any way could have been in the office looking at charts or doing anything else until we knew how big the problem was. So we wanted to take a small period of time -- and I wasn't expecting Aidan back just so quickly. I had no (inaudible) we had -- we didn't expect him back just so soon. But then it became very clear that he was obviously coming back. He had a theatre list. We thought we really need to bottom this out a bit more before he gets back to work.

So I suppose that was sort of the reasoning. We never meant it was going to be a long period of time, and I don't think it was long period of time, but I accept it may have had a very serious effect on him that wasn't intended.

MRS O'BRIEN: But why was it necessary? I don't accept that protection of patients and protection of clinicians, I don't accept that.

DR WRIGHT: You know --

MRS O'BRIEN: Because it's jargon. It's jargon.

DR WRIGHT: Well, because he was already coming in when he shouldn't have been at work. He was on Personal Information leave.

MRS O'BRIEN: This is the type of him. He works even when he's on annual leave.

DR WRIGHT: Well, I appreciate that. I know he does. But you shouldn't be in work when you're on Personal Information leave. That's that. You're either on Personal Information redacted by leave or you're not.

MRS O'BRIEN: He wouldn't have been -- he would have just been coming in with work for, you know, to do.

DR WRIGHT: But -- well, maybe in hindsight would I do the same again? Possibly not.

MRS O'BRIEN: Well, thank you for that.

DR WRIGHT: Possibly not.

MRS O'BRIEN: Thank you for your honesty on that.

DR WRIGHT: But the intention was certainly not to punish him. In many ways it was to try and get the thing moving forward as quickly as we could at the start.

Now, what I want to tell you about the investigation, and part of the reason why it was so slow to get going, was, to be honest, I wanted to make sure we had investigators and so on who were not part of this whole set-up, as you have described, as it became clear there were issues within the team and the team management. We needed to get people who aren't involved in this in anyway. And that was quite difficult to do (inaudible). So that took a bit longer than normal it would have taken.

MRS O'BRIEN: And then that~~ere~~ was a disaster.

DR WRIGHT: I don't --

MRS O'BRIEN: Colin Weir

DR WRIGHT: Well --

MRS O'BRIEN: Colin Weir had never conducted an investigation before whereas it says in all these things you should have people who are experienced at it. Colin had to be then, as he told Aidan, on legal advice he had to step down because he was a potential witness.

DR WRIGHT: And then yes.

MRS O'BRIEN: And then we had Neta Chada.

DR WRIGHT: And then Neta came in.

MRS O'BRIEN: And Neta. And Neta should have interviewed the practitioner first. Neta didn't. She interviewed all the witnesses first before. So that has an effect on a person's mind because the people who are being interviewed are -- don't want to leave themselves open. They're protecting themselves at all cost. There was quite a few things of real confusion that Aidan took a long time to -- for Neta Chada to understand. She -- it -- was so convinced of everything she had been told. She should have -- you should interview the practitioner first.

DR WRIGHT: Mmm.

MRS O'BRIEN: And then you interview (inaudible) and then you interview the practitioner again. I mean, you have no idea how badly this thing has been conducted. It's not just the injustice of it in the first place, but then when it did get going it is just incredible.

My son has accompanied Aidan. My son's a lawyer. My son when he was a third-year law student and he used to work part-time in Personal Information redacted by the. There was another boy with him who -- there was an allegation that he had taken something out of the till or whatever. So there was a little investigation set up. And, again, similar procedures. You can be accompanied by someone, a colleague or whatever. So this little boy he asked Personal Information redacted by the to go with him.

Now Personal Information redacted by the said -- and that's many, many years ago -- Personal Information redacted by the said the standard by which that investigation happened in a Personal Information redacted by the USI was masterful. It was so well done. Everything to the book. Personal Information redacted by the is aghast at this. He just cannot take it in. You know, he just cannot take it in.

Now you see the investigation -- you see:

"Where it is appropriate if it poses a threat or a risk to patient safety."

Aidan is no threat to patient safety.

DR WRIGHT: Right. I suppose the triage thing, you see potentially, would have been if there were people that were not being triaged that needed to be seen. Potentially. So that could

have been a threat ~~(inaudible)~~ but (inaudible).

MRS O'BRIEN: But not a future ~~let~~ threat. If you had said to Aidan, right, let's work out a programme here of a return to work. Aidan, will you agree to return all the charts? I will, Richard. Will you agree to do triage? I will. Will you agree to dictate as you go along? I will. Threat gone. Where's the future threat? That was the --

DR WRIGHT: Yes.

MRS O'BRIEN: I just cannot come to terms with it, Richard. I cannot come to terms with it. You look at this check list before deciding to investigate~~ion~~ and it says "the concerns identified and referred to the responsible manager." The concerns that was referred to you. The next thing is the practitioner is normally ~~provided~~notified of ~~with~~ the concern. Wasn't done. Written confirmation of the concern to the practitioner. Not done. First meeting with the practitioner. Not done. Meeting date agreed for the decision-making group. Well, that probably was done because you~~s~~ all met. Additional information assembled. And then, last thing, the decision made on whether to investigate. This is -- I mean, am I reading this wrong?

DR WRIGHT: (Inaudible).

MRS O'BRIEN: I just -- I cannot get my head round it.

"Specific procedures must be followed to ensure that a suspension or exclusion is lawful."

What does that mean? What does that mean? Does that mean that it's done in accordance with this, your -- the terms and conditions of your employment? It says suspension or exclusion should only be used -- only be used -- where there is no reasonable alternative. And the reasonable alternative wasn't even explored. I just don't understand that. I don't understand it.

I have gone through all of that and they all say the same thing and then I look at Aidan O'Brien who never seeks glory for himself. I used to say to Aidan, when he would be so frustrated by the things were done, I used to say to him, why don't you apply for that medical director and you could effect real change. He said no. He said I came into medicine to look after patients and that's what I'll do. Is Aidan, even with all of this happening, and I would say to him it's just tainted everything for me. And Aidan would say but it hasn't tainted it for me, Personal Information redacted by, because I can put my hand on my heart and I know that I have done my job so well. I have no regrets about anything.

But as I said to you that day, I sacrificed an awful lot for Aidan's job. I never put demands on him. I never -- I did complain of course sometimes when he wouldn't come home early. Never home before 9/10/11 o'clock at night day in day out. He works every

day of the week including Saturday and Sunday. I think the worst thing ever happened was that they do have Trust computers now because he's in his office all the time doing it.

There is just no let up. He takes the responsibility of all those people on those waiting lists on his shoulders. And the Trust doesn't seem to take the responsibility and he bears that burden. Comes into his office every evening after he has finished his clinical work and the desk is covered with post-its. This GP ringing. This patient ringing. People all desperately wanting to get into hospital and he's doing his best for them. And then this is what his employer does to him after 20 ~~---(inaudible.).~~

I was thinking I must take all these to Roberta to see why -- as I said to Shane, that day I was here, Aidan was 25 years here there. He took up post on 2 July 1992. And on 2 July 2017 I said to him, when he came home, did anyone come up, did anyone say you're here 25 years? He said no.

And I lifted the phone to the chief executive I said, you know, I said who I was. And I said Aidan has been there 25 years and I said there hasn't been one acknowledgement of it. She was quite ~~answer~~ taken aback the wee girl and she said that the chief executive -- there was no chief executive at that time last year. So she can't back to me a few days later and she said, you know, there is recognition of it. You can apply for long-term leave. I said that doesn't do it for me. I said someone from management -- I mean -- should make an effort I think --

DR WRIGHT: I think that's a fair point actually.

MRS O'BRIEN: -- to say, you know, you're here 25 years.

DR WRIGHT: Because there probably aren't that many people (inaudible).

MRS O'BRIEN: There's a lot actually because then I was saying this to Shane and Shane said to me, he says, well I am amazed at that. Because, he said, I have signed three letters for people today for long service, signed three congratulatory letters. I didn't ask him how that's generated. Maybe it is only generated when the people actually apply for the leave. I don't know.

DR WRIGHT: It might be the case (inaudible).

MRS O'BRIEN: I said to myself, I wouldn't be surprised now -- I am not being demeaning to other ancillary staff -- but sometimes I think in the health service there's this notion that, oh, because consultants are well paid that you don't need recognition for anything. It was probably -- I would say the porters would have got a letter.

DR WRIGHT: You might be right.

MRS O'BRIEN: The kitchen ladies would have got a letter for long service but not the consultants. Maybe the nurses. I don't know. But it's a very demoralised work force and

A one of the things that needs to be addressed is just supporting your work force, acknowledging that they are under a lot of stress and acknowledging the good work they're doing. I mean, I just thought it was awful.

I was sitting, that first time I met Shane, at that event that we were at and at the table was another girl, who's a pharmacist in the hospital, and we were talking. She was asking me how long was Aidan there and, you know, was Aidan was going to retire and whatever. I said no, not yet. I just happened to say to her, you know, he was there 25 years last months and I says there wasn't even an acknowledgement of it. And she said, oh my goodness she said, I was here -- I don't whether she was there 25 or 20 -- and she got a letter. She was a pharmacist. I don't know. I don't know whether doctors are just ...

DR WRIGHT: Mmm.

MRS O'BRIEN: But it's a very sorry state of affairs and I am hoping that after today, now that I have unburdened myself with all these concerns that I have had, and I do think you have taken it on board, and I think you were listening to me and listening to everything that I have to say, but it was still unjust. It was -- the decision was made too rashly, too quickly. There wasn't double-checking. At the end of the day, you are talking about a very senior person who has given 24 years work and I think that deserves a double-check. It certainly deserves speaking to the person involved first. And there could have been alternatives to the exclusion and to the formal investigation. There was no need for it. It has caused great hurt. Great, great hurt. Great disappointment. But I just admire Aidan so much. He's come back to work there (inaudible).

DR WRIGHT: He's done very well.

MRS O'BRIEN: And do you know something? He has never mentioned the investigation once to anybody. I have actually said to --

DR WRIGHT: No, he's showing -- I have to say he's showing great fortitude and character and I admire that.

MRS O'BRIEN: Thank you because and --

DR WRIGHT: (Inaudible).

MRS O'BRIEN: -- I think the hurtful thing too is, it has been hurtful I'd say, it's been hurtful to me. Do you know that not one of his colleagues lifted a phone to him and he started off that unit.

DR WRIGHT: I know he did actually.

MRS O'BRIEN: He was there on his own for so long. I remember when he was there on his own. And we knew John Templeton very well, he was the chief executive, and the time he was trying to poach Aidan for the job. I remember I was so concerned about the amount

of work he was doing. I lifted the phone one day to John in the evening at home and I said, John, something has to be done. Aidan is just working so hard. It's just -- he couldn't survive this. He said to me, Personal Information redacted by, Aidan is just going to have to walk away but Aidan's not that type of person.

DR WRIGHT: No, I know. I appreciate that.

MRS O'BRIEN: So when I think of all of that, I think to myself, why was this done to him. And then you know, as I say, Aidan has abided by everything in that investigation.

DR WRIGHT: Yes he has.

MRS O'BRIEN: And when he got the letter from Ahmed Khan to say that the investigator's report was in and you're given ten working days for your response. And when he got that letter, he was already scheduled to go to scientific meeting in Liverpool the following week. He had all his own work to do and then he had the Enniskillen clinic that following morning, so he couldn't leave it in. And Aidan is very thorough about things. He likes to give it his full attention. So he said, you know, I don't think -- could I have an extension on this? He was given 24 hours. Even though on the thing it says you should allow the -- if it is because of annual leave, or anything like that, an extension should be granted. So the extension was 24 hours. Then he leaves it in only to be informed that Ahmed was on a month's leave. Wouldn't even be looking at it.

DR WRIGHT: It was unplanned to be fair to him.

MRS O'BRIEN: You know, Aidan could have spent much more time on it. I think (inaudible).

DR WRIGHT: Okay.

MRS O'BRIEN: But.

DR WRIGHT: Right. Thank you for coming in. I've listened. I have listened to what you said. You make some very fair points.

MRS O'BRIEN: You think if you were to do it all again, Richard, would you have done it differently?

DR WRIGHT: Well, I think (inaudible) I wouldn't have started it from where we were. I think we were in a very ...

MRS O'BRIEN: I thought the day on the 30th -- I think you felt uncomfortable that day. You never mentioned the word exclusion once on 30 December. It had to be that girl ~~Ha~~Hainey ~~-~~ Hainey who said it. You never mentioned it once. You didn't. You said I think maybe you need another few weeks off. (inaudible) like.

DR WRIGHT: Okay. Well, that is -- I mean, I think -- I think on reflection if we could have got Aidan to agree to stay off for a few more weeks that would have been a better way

(inaudible).

MRS O'BRIEN: I think so. That was the solution.

DR WRIGHT: I think we were concerned that he was already coming in on Personal Information leave and that --

MRS O'BRIEN: Why was that a concern?

DR WRIGHT: We wouldn't normally allow any person to come who's deemed to be unfit to work. They shouldn't be in work. So that's, you know -- that's very unusual. I've never known --

MRS O'BRIEN: Aidan is a very unusual person I suppose.

DR WRIGHT: ~~(Inaudible)~~ Well I know, but you know what I mean. So I suppose -- and that was colouring the decision.

MRS O'BRIEN: (Inaudible).

DR WRIGHT: It wasn't -- I just say it again, it was never meant to be a punishment. It was meant to try and get the process going in fact. It clearly hasn't panned out (inaudible) way either of us would have wanted this. It's not in my interest for this to have gone on. I didn't expect it to take so long.

MRS O'BRIEN: But there was -- the unfortunate thing about this was the characters involved in management. Now, there was -- there's a bias there which I am telling you. I knew the names.

DR WRIGHT: I honestly don't --

MRS O'BRIEN: You see, you weren't there.

DR WRIGHT: -- know

MRS O'BRIEN: Yes, you don't know because --

DR WRIGHT: But I hear what you're saying.

MRS O'BRIEN: Yes. most definitely.

DR WRIGHT: And you probably won't have --

MRS O'BRIEN: (Inaudible).

DR WRIGHT: -- (inaudible) totally escaped you the fact that the MD for surgery, as was then, was not the MD for very much longer after that.

MRS O'BRIEN: And, as well as that, you know, the names.

DR WRIGHT: Suffice to say.

MRS O'BRIEN: Ronan Carroll, Simon Gibson. Simon was probably the conduit to you from Ronan and Eamon Mackle~~cIll~~. Now, those three people -- those three people in 2010 really, you know, there was major changes tried to be implemented and urology were -- and Aidan was just the spokesman for his other two colleagues because they all

were on the same agreement -- and there was major, major changes made. They were trying to prevent them but it was enforced and it was an absolute disaster and it all had to be dismantled again and tried to get back. And I have no doubt in my mind there was resentment there that -- because Aidan fought so hard for it, for it not to happen.

DR WRIGHT: No, I don't know.

MRS O'BRIEN: But I just think -- I just think the way, you know, like Ronan bypassing clinical management. He just went on ahead.

DR WRIGHT: I suppose the problem (inaudible).

MRS O'BRIEN: Clinical management.

DR WRIGHT: Clinical management was Eamon (inaudible).

MRS O'BRIEN: No, Eamon was gone in April. He bypassed Colin. He expressly said -- in the witness statements he expressly told them not to speak to Aidan.

DR WRIGHT: Right.

MRS O'BRIEN: Which I think it's very, very annoying.

DR WRIGHT: Look, what can I say. I am sorry it has taken so long. I hope we get an outcome -- ~~(inaudible).~~

MRS O'BRIEN: Apparently --

DR WRIGHT: I'm sure there'll be a lot of learning (inaudible).

MRS O'BRIEN: The latest is it's going to be October according to -- Aidan rang John Wilkinson yesterday.

DR WRIGHT: Right

MRS O'BRIEN: And, I mean, that's been a complete disappointment as well, the non-executive person. You see, I look at things -- maybe I am a very black and white person. But if I had of been -- if I was a member of a non-executive board and I was appointed to it, once -- I would have been looking through and I would have said, right, okay, all right, there's a room for -- in exceptional circumstances it might go on a bit longer. But do you see when it would have come to March, I, as the non -- I was saying this to Roberta, I would have been saying -- I would have been going down to whoever it be (inaudible). We have to call a halt to this. This is illegal. This is a breach of this employee's terms and conditions of employment. We have to stop this. You have to stop right now.

DR WRIGHT: But then if you had done that, I'm just thinking actually if that had happened that would have left everything hanging (inaudible). In some ways it might be satisfactory to get an outcome.

MRS O'BRIEN: But you see like --

DR WRIGHT: (Inaudible).

MRS O'BRIEN: -- you know, all that concern about the undictated things. You see that 189.

DR WRIGHT: If that's right --

MRS O'BRIEN: Not one of those patients -- there's nothing. There's nothing has happened. Nothing has happened.

DR WRIGHT: That's good. (Inaudible).

MRS O'BRIEN: And the thing about is that in March 2016 -- the exact same concerns were exactly the same in March 16 as they were in December 16. There's no difference. But suddenly it was (inaudible).

DR WRIGHT: I suppose from my perspective I had been probably naively assuming that in the interim period that Aidan and the management team had been working together to resolve a lot those issues. So it was a bit of a surprise when I discovered. And then once I realised they were still (inaudible) I can't know about this and not act. So I would accept it shouldn't have been there in that position. ~~(inaudible).~~ However, anyway, thank you for coming in to speak to me. I am glad we've had this conversation. Sorry I missed you earlier.

~~(Audio ends)~~

2nd March 2017, he recalls that you telephoned him and expressed concerns about case progression and time scales, stating that Mr. O'Brien was a highly skilled surgeon, had built up the Urology Department and was well-respected by the service users. 14:37

"She further expressed concern about the handling of the case by Human Resources, pointing out that the case was having an adverse effect on Mr. O'Brien and his wife and asking Mr. Wilkinson to contact Mr. O'Brien". 14:38

Do you remember engaging with Mr. Wilkinson in those terms?

A. Yes. I can only think the 2nd March '17 must have been the same day that Mrs. O'Brien phoned the office. 14:38

150 Q. Yes.

A. Because I would have actioned that immediately. I'm assuming I phoned him after that to say the concerns, the time scales and progression, and that it was having an effect, as listed there. I mean, I did. I didn't 14:38 know the date but I'm assuming that's what it would be. Yes, I did.

151 Q. Do you see in any of what he describes as inappropriate behaviour on the part of you as the Chair? You're taking information, whether from the telephone call 14:38 from Mrs. O'Brien or from your home visit to Mr. O'Brien, and you are relaying to Mr. Wilkinson their views and perhaps aligning yourself with their views about how Human Resources was handling the

process?

A. Mr. Wolfe, I would think by 2nd March '17 that John Wilkinson had already met Mr. O'Brien. Remember when I did the home visit, he hadn't. So, this call, I do not believe was to discuss the home visit; it must have been after the Mrs. O'Brien call. I'm just clarifying dates there. 14:39

152 Q. Yes, but in terms of the information you're receiving, you're building up a picture of the O'Briens' views of the process. That is coming to you because of your personal relationship with them, isn't that right? They know to pick -- she can pick up the phone to you because she has your phone number as a friend? 14:39

A. No, Mrs. O'Brien never phoned me to my mobile. The phone call that Mrs. O'Brien made was to the landline in the office of headquarters. Never did she do that. 14:40

153 Q. But the point I'm making to you is she's the spouse of an employee of the Trust, she's phoning you because she knows who you are, she has a relationship or friendship with you, and it's on that basis that she's able to make contact with you and share with you her and her husband's feelings about how they were being treated. You offer the view to Mr. Wilkinson that these are matters that you will work on on their behalf by passing the information into the system. 14:40 14:41

Should you not have been stepping away from any engagement with the O'Briens on this, wearing your professional hat?

A. Can I come back to that one in a minute? I just want to say that what Mr. John Wilkinson's is saying there, that I expressed concern about the case progression and time scales, that is what I was phoning him about because Mrs. O'Brien had phoned the office. That's just a point. 14:41

I would have had -- I mean, I can think of other consultants who would have phoned to express concerns and I would have done the same, Mr. Wolfe, of informing the Chief Executive or whatever. I do remember one consultant phoning me who did not accept the offer of Non-Executive Director, and why. I think I have covered that before. 14:41

14:42

So, should I have been stepping back? If I knew then what I know now from this inquiry, I would not have been involved in this, but in that instance that we are referring to I believe all I was doing, having told the Chief Executive about the call and the non-executive that was responsible for this process of timelines and how it was being taken forward, I was telling John Wilkinson I've had a call from Mrs. O'Brien and explained what it was. That's what I believe I was doing in that case at that time. 14:42 14:42

154 Q. The point is, if I could just deal with it succinctly, where you are receiving representations from an employee, where you know you have a conflict of interest, should you not have been inviting the

employee or his spouse to take the matter up at the appropriate entry point in the process, in other words directly with Mr. Wilkinson because they have his contact details, or directly with Human Resources with whom you are in your contact with Mr. Wilkinson, 14:43
expressing some concern or criticism? Is that not the way it should have been handled?

A. Yes, I was expressing concern to John Wilkinson about the length of time it was taking, hence what Mrs. O'Brien had told me. You're asking me should I 14:43
have stood back and not done that?

155 Q. Yes.

A. At the time I didn't honestly think of doing that. I'm just saying to you on reflection --

156 Q. Is it fair to say that you didn't conceive of doing 14:44
that, that is you didn't conceive of stepping back, because you were so closely linked to Mr. O'Brien by reasons of friendship and what have you, that you thought it appropriate to continue to go in and bat for him, to express your concerns on his behalf to the 14:44
likes of Mr. Wilkinson so that things might be progressed more favourably or, in the particular context of this, more expeditiously? Isn't that what was happening?

A. Sorry, I didn't see myself on that occasion for using 14:44
the word "batting" for Mr. O'Brien. I was making a phone call to the Non-Executive Director responsible for the timeframe and saying here are the concerns. But I didn't at that time believe that I was advocating

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

Please provide all relevant documentation.

Mr O'Brien never made a complaint to me about Mr Mackle, bullying or otherwise.

48. **Martina Corrigan** has provided information to the Inquiry as follows:

(i) "*I have an awareness of at least two occasions where managers had been asked to step back from managing Mr. O'Brien. In approximately 2011/2012 Mr. Mackle had been advised that he was being accused of bullying and harassment towards Mr. O'Brien and that he needed to step back from managing him. I was not present when Mr. Mackle was told this, but he came straight to me after this happened, told me about it, and was visibly annoyed and shaken and said to me that he would no longer be able to manage Mr. O'Brien. I also understand that, in mid-2016, Mrs Gishkori received a phone call from the then Chair of the Trust, Mrs Brownlee, and was requested to stop an investigation into Mr. O'Brien's practice. Once again, I did not witness this, but I was told later by Mr. Carroll that it happened as my understanding is that Mrs Gishkori had told some of her team*." **WIT 26224 - 26225**.

This account from Martina Corrigan is third hand. Martina states that she heard from some unnamed member of Esther Gishkori's team that I had asked Esther to halt an investigation into Mr O'Brien? I would never interfere in due process in this way patient safety was always my top priority, and I have absolutely no doubt that Esther will confirm that this never happened. I never made any phone call to Esther Gishori about Mr O'Brien

(ii) At 24/22 at para 67.5 – "*It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr.*

[redacted]: That's exactly.

JOHN WILKINSON: Okay.

[redacted]: There is also another issue with regard to this meeting and that is that, whilst we don't want to personalise the issue, Mr Mackle~~cIll~~ should not have been involved at all because my father had had a formal grievance against Mr Mackle~~cIll~~. Now that grievance was stayed effectively.

MR O'BRIEN: I suspended it because [redacted] and with the -- on condition that I could initiate it again at any time in the future, which I haven't done. And, you know, one can only speculate as to whether this letter would have been followed up with some kind of informal attempt to resolve the issues had it been someone other than Eamon Mackle~~cIll~~, but, in a sense, that's secondary to the fact that there was no informal process.

JOHN WILKINSON: Okay. But so you're -- I've got the first scenario. The second scenario is that there was a case sitting with regards -- as it were, suspended by you against Mr Mackle~~cIll~~ and he was -- is he your direct line manager?

MR O'BRIEN: Not my first line manager. The lead clinician is Mr Young.

JOHN WILKINSON: Sorry, I do know him. That's a problem for you?

MR O'BRIEN: No, it's not at all. No.

JOHN WILKINSON: [redacted] So as long as there is no problem for you.

MR O'BRIEN: No. None whatsoever.

JOHN WILKINSON: Okay. Right. So there was -- if we look at it then, he was a couple of --

MR O'BRIEN: People about that, yes, associate medical director, yes.

JOHN WILKINSON: All right.

MR O'BRIEN: At that time. He's no longer.

JOHN WILKINSON: Right. Okay

[redacted]: But it had also been agreed at that time of the -- around that time the grievances were being issued that he would have no dealings with him again.

MR O'BRIEN: Yes. I sought and obtained an assurance from Dr Rankin and from Eamon Mackle~~cIll~~ himself, particularly from Dr Rankin, that I would have no more dealings or meetings with him because I was on the point of breakdown as a consequence of his treatment over a period of years. But anyhow, as I said to you --

I absolutely refute everything that Martina Corrigan has said about me. I cannot comment on what she alleges Mr O'Brien communicated to her.

If Martina Corrigan had such serious concerns about me, concerns that went to the heart of the Governance and integrity of the Trust, then I wonder – as a Senior Manager – what she did to address those?

I would never attempt to interfere in any investigation or to try to interrupt due process in any way; not least because I know how any such request would rightfully be received by the relevant professional. I have enough faith in my colleagues to expect that I would be reported immediately for such behaviour.

It causes me great concern to think that Martina Corrigan, Head of Service, and responsible for delivery of Urology services, believed the Trust Board to be so corrupt yet fail to take any action about that.

MHPS

49. At the confidential Board meeting of 27 January 2017 (**TRU 112984-990**) the Board appears to be informed for the first time of Mr. O'Brien's exclusion and planned return to work, under the heading of Agenda item 6 "*Maintaining High Professional Standards (Exclusions)*". You attended this meeting and, while it is noted that you left before this item on the agenda was reached, you did not declare a conflict of interest. Why did you leave the meeting? Given what others have said about your friendship with Mr. O'Brien and your role with CURE (see Questions 42 and 48 above), should you have declared a conflict of interest at this point? Why did you not declare a conflict of interest?

By leaving the meeting I was declaring an interest and all members of the Board were aware of why I was leaving for that particular item. This may have been left out of the minutes of the meeting, but I have no doubt the Board were aware as to why I was leaving for that agenda item.

50. When you were first made aware of concerns regarding the practice of Mr. O'Brien, did you recognise you had a conflict of interest if you were to take part

the same time.

321 Q. How did they receive the information?

A. Mr. Rice was very understanding. He was obviously aware of the ongoing difficulties and understood and was supportive. When I had to see Mrs. -- I have a mental blank -- Brownlee, she listened quietly and I was aware obviously there was a friendship between Mrs. Brownlee and Mr. O'Brien, but she listened professionally and she agreed she would identify a Trust Board member to act as the designated person, as was her role, and she was quite understanding. 15:18 15:18

322 Q. The purpose in speaking to them was the formality of informing them that an employee, a clinical employee had been excluded?

A. That was one aspect of it. As far as the Chief Executive, he needed to be aware that it was a formal exclusion or an immediate exclusion of one of his employees and he needed to be aware of the reasons for that, so that was simply a matter of updating him on that. For Mrs. Brownlee it would have been the need to appoint a designated Board member in the first instance. 15:19 15:19

323 Q. What was the reason for the exclusion?

A. We discussed the case with NCAS, who were in agreement with our decision for immediate exclusion. This is not a formal exclusion. It's an immediate exclusion for a brief period of time, for a few weeks. They agreed that in order to scope the size of the problem, for Mr. Weir to complete his investigation, without any 15:20

"I would want to explain regarding Mr. O'Brien. Can you let me know and then we can chat first?".

In terms of what you knew about the relationship between Mr. O'Brien and Mrs. Brownlee, that friendship, had you any concern about approaching her in this way? 15:39

A. No. No concern. I mean, it just was part of the process and had to be done. I was aware that Dr. Wright had already spoken to her about it. I think he went in to actually speak to her about it. It was part of the process. 15:39

264 Q. Was this the sum total of your contact with her on the issue. I know you had go to the Trust Board. We'll come to that in just a second. Is that the contact that you had with her on it? 15:40

A. There was one discussion with her, and I don't know why I would have been in her office. Her office is literally just across the corridor from mine. I might have been in for some other reason. It was during January. I don't know a date. She did express to me her unhappiness, I suppose, maybe is a way to describe it, in relation to Mr. O'Brien's exclusion. 15:40

I think it was in the context of this, you know, he's a very hard-working, excellent clinician, that type of language. Those are my words, I'm not quoting her. But my response, I mean it was a very short exchange, and my response to her was, 'these are serious issues, Roberta, and they need to be looked at'. That was the 15:41

sum total of our conversation and she never brought it up with me again.

265 Q. In your view was that an appropriate encounter from her perspective or do you think she shouldn't have touched that issue with you? 15:41

A. No. I don't think she should have touched it with me. No.

266 Q. That's as far as it went, this expression of unhappiness?

A. Yes. She wasn't asking me to do anything. She wasn't. 15:41 There was no instruction or anything like that. It was just to let me know that she was unhappy about it.

267 Q. Is it fair to characterise that she was unhappy, she was letting you know, but there was no pressure on you to change course? 15:42

A. No, and I didn't feel that pressure, to be honest. I just didn't think it was an appropriate thing but it wouldn't -- there was no instruction, nor did I feel a pressure to change the course of where we were heading. 15:42

268 Q. Did any other participant in the process speak to you about any perception of inappropriate approaches from Mrs. Brownlee?

A. No.

269 Q. Thank you. In terms of your contact with the Board, 15:43 can I just bring up -- you went to the Board on 27th January. Can I bring up a draft record and perhaps you can help me to understand how this could have come about. TRU-263865. This is referred to as