MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 17TH MAY 2023 - DAY 42

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WITNESS PAGE

THE HEARING COMMENCED ON WEDNESDAY, 17TH MAY 2023, AS FOLLOWS:

CHAIRPERSON: Good morning, thank you.

MS. KILEY: Good morning Chair, Panel. Chair, this morning's witness is Mr. Brendan Whittle who is giving evidence on behalf of the SPGG, formerly Health and Social Care Board, so he is ready whenever the Panel is ready. 10:01

CHAIRPERSON: Let's bring the witness in, thank you. 10:01

MR. BRENDAN WHITTLE, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY, AS FOLLOWS:

CHAIRPERSON: Good morning, Mr. Whittle, thank you very much for your statement and for joining us this morning. We've met very briefly outside, and I am going to hand you over to Ms. Kiley. If you need a break at any stage just say so and we'll stop. But we normally try and sit until about quarter-past-11, then take a break, and then obviously stop at lunch again, okay. 10:02 10:03

MS. KILEY: Good morning, Mr. Whittle. We met briefly this morning. As you know, I am Denise Kiley, one of the counsel to the Inquiry and I am going to be taking you through your evidence today. 10:03

I see you have a number of documents in front of you. You have made a statement to the Inquiry on behalf of

the Strategic Planning and Performance Group which I am going to be referring to as "SPPG" and that statement is dated the 10th February 2023. Do you have a copy of that in front of you?

A. Yes, I have a copy of my statement in front of me and I have a number of exhibits which I also have on the desk with me. 10:03

1 Q. Okay. So, the statement itself is 119 pages and I think you have 230 exhibits, so it's pretty lengthy. I know you have hard copies of some. I will be calling up some documents and you will see them on the screen in front of you, so if I want to refer you to something feel free to use the screen or your hard copy if you have it. But just pausing on the statement for now, Mr. Whittle, do you wish to adopt that as the basis of your evidence to the Inquiry? 10:04 10:04

A. I do.

2 Q. And you say in your statement that you are presently the Director of Hospital and Community Care at SPPG, is that right? 10:04

A. That's right.

3 Q. Your background is a social worker, is that right?

A. That's right, yes.

4 Q. And in fact at paragraph 1.4 of your statement you set out the various senior roles which you have had in your career and looking at those it appears that you joined the Health and Social Care Board which was SPPG predecessor in April 2019, is that right? 10:04

A. That's correct.

5 Q. And your role then was Deputy Director of Social Care and Children, is that right?

A. Yes.

6 Q. And you then held the role of Director in that post from April 2021?

A. Yes.

7 Q. And that's the role which you currently hold in the newly formed SPPG?

A. No, there was an organisational change in SPPG in the summer of last year. One of my colleague directors became critically unwell and in that period of time I assumed additional responsibilities, so as well as taking responsibilities of Director of Children and Social Care, I also assumed responsibility for Hospital Services, Acute Hospital Services across Northern Ireland. I have done that since July of last year and hence the change in title to the Director of Hospital and Community Care.

8 Q. Yes okay, thank you for that. I am conscious that we are moving between reference to SPPG and HSCB and I do want to come on and explain and have you explain to the Panel how that change came about and what the structural changes were recently. So I'll come to that shortly.

But your statement addresses a number of topics which The Inquiry requested assistance with and, as you know, The Inquiry is presently dealing with six defined evidence modules. I am going to ask for the evidence

modules document to be brought up on your screen just to orientate us as to what topics we are going to address today. Thank you. So if you could scroll down to Module 2. And scroll down to bracket "D" please, yes, that's great if you pause there. 10:06

So, you have been asked to address Module 2D, H, and, I, so as you can see there, D is the Health and Social Care Board Strategic Planning and Performance Group. H is an explanation of the structures in place to promote 10:06 quality of care at M, A, H and I is an outline for the provision of community-based services. So those are the topics that you're dealing with in respect of Module 2.

10:07

Then if you can scroll down so we can see Module 3 on the screen. You will see Module 3 runs just beyond that page from topics A to M and your statement in fact deals with all of those sub-points. So we have rather a lot to get through. So, we've referred to your role 10:07 in SPPG and I think it's fair to say that there have been a significant number of changes at Board level over the years of the terms of reference which The Inquiry are looking at. The Health and Social Care Board which I have referred to no longer exists as a 10:07 body, isn't that right?

A. That's correct.

9 Q. And that was replaced with SPPG in April 2022, is that right?

A. The Health and Social Care Board was dissolved and at that point the functions of the Health and Social Care Board were assumed into the Department of Health, so the SPPG is not a legal body, it is part of the Department of Health. I think you'll recall that when Mark McGuicken gave his evidence he referred to there being eight groups within the Department, the Strategic Planning and Performance Group is one of those groups within the Department. 10:08

10 Q. So it's fully integrated within the Department and that's a change from the earlier position because the HSCB was an arm's length body, isn't that right? 10:08

A. That's correct.

11 Q. Can you tell the Panel any more about the reason for that structural change? 10:08

A. It was a decision by the Minister to, if you just bear with me one second while I go to my evidence, sorry, you wouldn't just point me to the page on the statement?

12 Q. Yes, you deal with this Mr. Whittle at - you provide an initial summary at paragraph 1.8 onwards. But in terms of the change to SPPG that I wanted to ask you about, I know you're looking perhaps for documents that introduced the change, but I don't particularly want you to go into that level of detail at that stage in terms of policy. But my question is really directed in the reason for the structural change. 10:09 10:09

So you have explained to me there that the change in

SPPG was that it was fully incorporated into the Department as compared to an arm's length body. What I wanted you to explain briefly is just the reason why that structural and governance change occurred, if you're able to. I appreciate it was a departmental decision, isn't that right?

A. Yes. I mean ultimately that would be the decision for the Department and for Minister so there was a decision taken to close the Board. My understanding of that decision was that there was a desire that the Health and Social Care Board's functions with regard to performance, management, financial management and planning would be more closely aligned to the Department of Health as opposed to within an arm's length body, which was the previous function. That had followed a number of reports which had been written, the Donaldson Report which had made recommendations, the decision was taken by Samuel Hamilton who was the Minister at the time to close the Board. That was some five years before the Board actually closed, but at that period of time the plans were put in place for the dissolution of the Board and the transfer of the functions to the Department of Health.

13 Q. Just to focus in on that, you referred to the Board a few times as being "closed" and, just to be clear, this is not a case where we see in sometimes that a body changes it's name. It's actually the case that the Health and Social Care Board as an entity no longer exists?

A. The Health and Social Care Board as an arm's length body no longer exists under its previous governance structures. It would have had a Board's Board, a Chairman, it would have had its own government structure. That has now been dissolved and the function of the Strategic Planning Performance Group falls within the organisational arrangements of the Department of Health.

So, by way of example, as a Director of the Strategic Planning Performance Group, I would directly report to Deputy Secretary within the Department of health who in turn would report to the Permanent Secretary.

14 Q. So SPPG a staff are now departmental staff, is that right?

A. Strategic Planning Performance Group work as a group of the Department but they are employed by the Business Services Organisation and that's for the staff of the former Health and Social Care Board were employed under HSC Health and Social Care Terms and Conditions, so to maintain those employment conditions they are employed by the Business Services Organisation so they are not civil servants as employment status, they are health and social care in terms of employment status, but to all intents and purposes, work as a group of the Department and there is no legal function of the Health and Social Care Board. Those powers and duties now fall to the Department of Health which is the SPPG exercises on the Department's behalf led by a Permanent

Secretary.

15 Q. Yes, thank you for that.

DR. MAXWELL: Can I just ask, you made reference to the Donaldson Report. Did the Donaldson Report specifically mention the HSCB and it should be closed? 10:12

A. I haven't exhibited the Donaldson Report in my evidence, so I would need to check that. My recollection is that it identified some criticisms with regard to the Commission arrangements. I don't believe that it made a direct recommendation to close the Board 10:13 but that's something I could certainly check and come back at a later point to clarify.

16 Q. DR. MAXWELL: Can I ask in practical operational terms, what is the difference between HSCB and SPGG in terms of operational day-to-day management? 10:13

A. In terms of the operational day-to-day management the functions remain the same. The difference is the closer working relationship, the accountability to the Department of Health. So as a Director of the Health and Social Care Board I would have been accountable to 10:13 my Board as an arm's length body, whereas now I am accountable through to the Department and Minister.

On a day-to-day basis that would mean things like, by way of example, my staff would write submissions to 10:13 Minister when there is a Minister in place and would write to the Departmental Secretary, whereas when we worked for an arm's length body we would not have done that. That would have done through the Health and

Social Care Board to the policy side of the Department who would have done that. So that direct line is there which does make a difference on a day-to-day basis. But the functions in terms of managing the money, managing the performance, managing the planning, that function remains the same.

17 Q. DR. MAXWELL: If the accountability arrangements have changed so they are direct to the Permanent Secretary, does that mean there's more political involvement in the running than there would have been with HSCB? 10:14

A. That's a difficult question for me to answer because I was only in the Health and Social Care Board as a Director for one year. What I would say is that the accountability and the alignment between SPPG and the Department is very close and my understanding is that that is something which was part of the policy intent in terms of the dissolvement of the Board and the establishment of the SPPG to ensure that there would be a closer relationship one between the other. 10:15

DR. MAXWELL: Thank you. 10:15

CHAIRPERSON: You've got quite a soft voice, could I just ask you to move the microphone more centrally and also up a little bit and that may help us.

A. Is that better, Chair?

CHAIRPERSON: I expect it is going to -- 10:15

DR. MAXWELL: I think it needs to stay closer to you.

CHAIRPERSON: Thank you very much.

MS. KILEY: Mr. Whittle, that is the recent change at Board level but there have in fact been other changes

throughout The Inquiry's Terms of Reference. You set out the history of the Boards in your statement. So what I want to do now is go through and establish the position that existed at various points of time that The Inquiry is looking at. So you deal with the early periods of what are referred to as "Legacy Boards" at paragraph 3.5 of your statement.

So, to clarify, you provide a significant amount of history about the establishment of the modern health and social care structure and the set-up of geographical Health and Social Services Boards, all that information is there for the Panel to see. But just to clarify, is it right to say that in 1999 there existed four Health and Social Services Boards? 10:16

A. Yes. There was a Northern Board, Eastern Board, Western Board and Southern Board.

18 Q. Yes. You explain their roles at paragraph 3.12 of your statement and you say, this is at page 9 of the statement if you could call that up please. You say there: 10:17

"Four HSSBs functioned as agents of the DOH exercising functioning of the DOH which had been delegated pursuant to Article 17 of the 1972 Order. They were charged with, amongst other things, identifying the health and social care needs of people living within their area and to commission services to meet those needs." 10:17

And you then go on to explain:

"This involved either the direct provision of services or commissioning contracts for care services with Health and Social Service Trusts when these were established. The general responsibility for identifying health and social care needs for people living in their area extended to all people, including people with a learning disability to ensure that services were available to meet their needs." 10:17 10:18

You've referred there to Trusts so I want to come on and ask about the relationship with that. And again, to ground us, in 1999 you deal with this at paragraph 3.8 just on the prior page, you say: 10:18

"In December 1999 there were 18 Health and Social Services Trusts."

They were the Bodies that provided hospital and community care at that time, isn't that right? 10:18

A. That's correct.

19 Q. And The Trust with responsibility for Muckamore Hospital was the North and Western Belfast Health and Social Services Trust, isn't that right? 10:18

A. That's correct.

20 Q. Okay, and just to establish it at Board level it was the Eastern Health and Social Services Board that had

responsibility for Muckamore at that time?
A. That's correct.
21 Q. At paragraph 3.20, you go on to explain the situation where patients from different Board areas were admitted to Muckamore Abbey Hospital and I want to just ask you some more detail about that. So you'll see at paragraph 3.20 you explain that:

"Each legacy HSSB with patients in Muckamore Abbey Hospital held individual contracts and responsibilities for their patients. Service budgets were introduced after the establishment of the HSCB who assumed responsibility for commissioning services for their patients. The contract agreement was between the relevant legacy HSSB and the North and West Belfast Trust."

You have referred to two different things there, service budget agreements and individual contracts. Could you explain to the Panel what the practical difference between those two things were, if there was any?
A. The service and budget agreement is the agreement between a Legacy Board and The Trust to provide services on its behalf and the service and budget agreement would break that down into the units that would be purchased, so the number of beds for example, would be established within a service budget agreement. In practical terms there is no difference between that

and the contracts and agreement. There would be the commission arrangements, the commission plan and then you would have a service budget agreement which would quantify the quantitative element of that plan.

22 Q. Okay. So does that mean that, in effect, for a patient who was at Muckamore Abbey Hospital whether it be; whatever way it be organised, a patient's own Board pays for that care but the North and West Belfast Trust provides the care, is that right? 10:20

A. Yes, the North and West Belfast Trust were the provider of the care. The contract was between the Legacy Board that had placed the patient there. So typically that would be the Eastern Health and Social Services Board or the Northern Health and Social Services Board or other Boards, and they would have had individual contractual arrangements with the North and West Belfast Trust to provide for patients on their behalf. 10:20 10:21

The change happened subsequently when the Health and Social Care Board, the Regional Board was established, and there was just one contract with the provider Trust, rather than multiple contracts when there were multiple, when there were four Health and Social Services Boards in place. 10:21

23 Q. And I'll come on to that change, but just thinking particularly about this time when there were multiple contracts. In that scenario who was ultimately responsible for the patient at Muckamore? 10:21

A. There would be a shared responsibility between the

provider Trust who would be responsible for the day-to-day care and safety of the patient. There would be responsibility for each Health and Social Services Trust shared with regard to patients that they had placed in The Trust. So that would be shared between The Trust that had -sorry, shared between the Health and Social Care Board who made the placement and The Trust. There would not be one Health and Social Services Board had who would have primacy in that circumstances, albeit the Eastern Health and Social Services Board my understanding were to have the bulk, the majority of the patients there, so would have had a close working relationship with the North and West Belfast Trust at that stage. 10:22 10:22

24 Q. Yes, but I'm just thinking at Board level. So if someone, you had mentioned sometimes that patients from different Board areas could be placed in Muckamore Abbey Hospital. So whenever there are two Boards involved, so the geographical area in which the patient lives and then the Board for Muckamore Abbey Hospital, at Board level who carried that primary responsibility for the patient that was placed in Muckamore? 10:22 10:23

A. The placing Trust.

25 Q. Okay.

A. Sorry, the placing Board. 10:23

26 Q. The placing Board. In terms of establishing that, was there a policy or procedure within the Board that established that it was the placing Board that carried that responsibility or that governed in any way the

relationships between the different Boards in those circumstances?

A. To my knowledge that was not covered by a policy or procedure.

27 Q. DR. MAXWELL: Can I just clarify that, excuse me, I am thinking about my experience in England, but the Commissioning Board, so the geographical Board is responsible for placing the contract and monitoring the delivery of the contract. But the "Provider Unit", as we would call it in England, the management of the hospital is responsible for delivering what's in the contract. So they are both equally responsible for different things. Would that be the same here in Northern Ireland? 10:23 10:23

A. Yes, in the sense that there would have been the North and West Belfast Trust which would have been the provider organisation and there would have been multiple purchaser commissioning organisations through the four Health and Social Care Boards. The Health and Social Care Boards retained a responsibility for the patient that they had placed. They would have had to have a contractual relationship with the North and West Belfast Trust which was established by the Service and Budget Agreement that I have referred to. So they retain responsibility for their patient, albeit the provider Trust, the North and West Belfast Health and Social Services Trust, provide responsibility for the provision of that care to the appropriate quality that one would expect. 10:24 10:24

28 Q. DR. MAXWELL: So the mechanism for the commissioning Board is through contract management, they would say you're not meeting the terms of the contract in delivering this service?

A. Yes, that's my understanding. 10:25

MS. KILEY: Okay, so that's the position in 1999. Just moving along the timeline that you have provided, it appears that there was a change in structure in 2007 which you deal with at paragraph 3.21 which is still on your screen and that was with the structural changes to 10:25 the Trusts. You explain North and West Belfast Trust merged with five other Trusts to become the Belfast Health and social care Trust in April 2007. You explain then that the EHSSB had lead responsibility for the North and West Belfast Trust and also the Belfast 10:25 Health and Social Care Trust between 2007 and 2009.

So just to clarify there, in 2007 there is a change at Trust level but at Board level, ultimately responsibilities in respect of Muckamore remained the 10:26 same, is that right?

A. Yes. The consequence of the Review of Public Administration the 18 Health and Social Services trusts were changed to six Health and Social Care Trusts, but there remained four Health and Social Services Boards 10:26 for a period of two years between 2007 and 2009 until the Regional Health and Social Care Board was established.

29 Q. Yes, and I want to ask you about that Regional Board

now. So, the Regional Board was established in April 2009, isn't that right?

A. That's correct.

30 Q. And you described the role carried out by the new Regional Board at paragraph 3.23 of your statement and I will just read that to you: 10:26

"The Regional Health and Social Care Board was established in 2009 pursuant to Section 7 of the 2009 Act. Its functions were set out in Section 8 of the 2009 Act. In essence, it was to exercise the functions of the previous HSSBs. 10:27

Its role as an arm's length body to the Department of Health was to arrange or commission a comprehensive range of modern and effective Health and Social Services for the population of Northern Ireland, to performance manage HSC Trusts that directly provide services to people to ensure that these achieve optimal quality and value for money in line with relevant government targets and within budget envelope available." 10:27 10:27

Now, I want to just focus in on the commissioning role for a moment. So, whenever that change happened the commissioning role, in effect, continued to be exercised by the Regional Board. So the role that the four Legacy Boards carried out continued to be exercised but at a single body level, is that right? 10:27

A. That's right.

31 Q. But the actual role didn't change?

A. That's right.

32 Q. In terms then of the second element that you have mentioned, the performance management role in respect of Trusts, was that a new role for the single Regional Board or was that something that had Legacy Boards had also exercised? 10:28

A. The Legacy Boards would also have a role with regards to performance management. 10:28

33 Q. DR. MAXWELL: Can I just clarify, so we talked earlier about the Regional boards managing a contract, so commissioning through a contract and managing the delivery of the contract, when it became a Regional HSC Board was that performance management going beyond the contracts to the service as a whole? 10:28

A. Perhaps if I could bring up page 132 on the evidence. That is exhibit BW4.

34 Q. MS. KILEY: This will come up on your screen shortly, Mr. Whittle. Page 132. Is this the document which you are referring to? 10:29

A. Yes. So you can see at paragraph 2.1.2 the Health and Social Care Board's functions can be summarised under three broad headings, "Commissioning, Performance Management and Service Improvement", and then the third one, if you just drop down the screen please, as Resource Management. 10:29

DR. MAXWELL: So that is --

A. That's taken from the Health and Social Care Board's

Management Statement and Financial Memorandum.

35 Q. DR. MAXWELL: So does that imply that the performance management function became broader when the HSCB came into existence than the previous Regional Boards?

A. That's something that I would need to clarify and come back to the Inquiry on, making reference to the management statement of the former Health and Social Services Boards to compare with the management statement that I provided as evidence, I'm happy to do that. 10:30

36 Q. MS. KILEY: You do in fact deal with the single Regional Board's performance management function in further details later in your statement, so I am going to come to that, I have more questions about that. But sticking with the structural changes and the new Regional Board. You explain the composition of the new Board at paragraph 3.26 of your statement. I don't intend to go through all of that, but again just to give us context Mr. Whittle, is this a fair summary, there was a Chair, and the Chair was appointed by the Minister of Health, is that right? 10:30

A. That's correct, yes.

37 Q. And then there is also a Chief Executive, is that right?

A. Yes. 10:31

38 Q. And there was then a prescribed amount of both Executive and Non-Executive Members, is that right?

A. Yes.

39 Q. And they collectively constituted the single Health and

Social Care Board?

A. Yes.

40 Q. Now, from the Non-Executive Board members then, there were four of those, isn't that right? I think you deal with this at Section 3.31 of your statement? 10:31

A. Yes, that's correct, four Executive Board members.

41 Q. And you set out the titles of each of those four members and then you deal with their responsibilities at paragraphs 3.3 to 3.37. Again, I am not going to go into all of those in detail. You've set that out for 10:31 the Panel. But I want to just ask you a little bit more about that performance management role that you have identified for those directors.

So, at paragraph 3.3, you refer to one of the directors 10:32 who is the Director of Performance Management and Service Improvement and you say that:

"They were responsible to the Chief Executive for the performance management of Health and Social Care Trusts 10:32 that directly provide services to people to ensure that these achieve optimal quality and value for money in line with relevant government targets, as outlined in the Minister's commissioning plan direction."

10:32

And you also refer to a performance management function held by the Director of Commissioning. You deal with that at paragraph 3.34. And you say:

"The Director of Commissioning was responsible to the Chief Executive for the development and implementation of coherent commissioning arrangements to drive up performance and standards in line with the extant commissioning direction indicated by the Minister for Health on an annual basis and any other relevant guidance or legislation."

Can I ask you just to explain to the Panel a little bit more about what the Health and Social Care Board, when it became a regional body, saw it's performance management function as being. You have explained it in terms of reference to the roles of the directors, but in practical terms, can you elaborate on what that meant to the Board? 10:32 10:33 10:33

A. Yes. Prior to 2009, performance management was a function of the Department of Health through a service delivery unit. The Health and Social Care Board performance management arrangements were in place from 2009, and from 2009 to March 2016 the performance management responsibilities focused on the Minister's targets and indicators of performance, a target being a target to do something for example, to achieve re-settlement, an indicator of performance being that when a target had passed but had not been achieved, an indicator of performance was then put in place to monitor that. 10:33 10:34

So the Board's role would have been in the performance

management the Trusts against the targets and indicators of performance that were established by government at the time. In addition to that, there are a number of performance management arrangements which I'll come on to in terms of my section 4 which will look at, for example, the delegated statutory functions report or the review of complaints which we shall come on to later I presume.

42 Q. Yes, I am going to ask you a little bit more about those in due course. But in terms of performance management you have mentioned targets and what I am really getting at is, was it just about targets, was the performance management function for the single Regional Board just about targets or was it something more than that, was the Board looking at quality of care in Muckamore Abbey Hospital? 10:34 10:34 10:35

A. Over and above targets, they would be looking at arrangements that were established in the commissioning plan that the Health and Social Care Board and the Public Health Agency put in place on the basis of the commissioning plan direction which is an annual direction given by the Department. That commissioning plan was much broader than the commissioning plan direction and there would have been performance management arrangements with regard to the requirements of that plan on an annual basis. You had the commissioning plan and the formal targets, both of which would have been monitored by the Director of Performance and Improvement. 10:35 10:35

43 Q. But where does the quality of care element come in there? Is the Board looking at what is actually happening on the ground in terms of the service that it is commissioning at Muckamore Abbey Hospital and, if it is doing that, how does it do that? 10:36

A. It would do - quality would be inherent in the commissioning plan direction. So the reasons for quality would integral to the performance management arrangements that were in place. There wouldn't, to my knowledge, be a separate quality report over and above 10:36 the commissioning plan direction or the targets that were performance managed at the time. There would be an element of quality that would be managed through the delegated statutory functions report process which, again, I think we'll come on to later. 10:36

44 Q. DR. MAXWELL: Can I ask if the commissioning plan had any metrics of quality?

A. I'm not aware if it did or it didn't.

45 Q. MS. KILEY: One of the things you say about the Director of commissioning in the extract that I have 10:36 just read to you is that one of their roles was to drive up performance. How did the Director of Commissioning assess the baseline from which to drive up performance? What sort of assessment process did they have, what data did they receive to be aware of 10:37 performance?

A. So, the Director of Commissioning and Director of Performance would have met on regular basis, I believe monthly, with the Health and Social Care Trusts over

the period and there would have been a range of quality metrics which would have been reported from the Health and Social Care Trusts to the Health and Social Care Board which would have been part of the - which would have been reported to the Health and Social Care Board's public meeting and would be publicly available, so those metrics can be provided to the Inquiry if helpful.

46 Q. Okay, and in terms of those meetings between the Directors and The Trusts, are you saying that the minutes of those meetings are available also, or just the later report to the Board? 10:37

A. The minutes would be available.

47 Q. Okay, and just before I leave the role of the Directors and sticking with the Director of Commissioning, was the Director of Commissioning in the Health and Social Care Board also responsible for monitoring the service that was delivered under the contract in any other way, aside from that way which you have just described, the relationship with the Trust? Do they monitor in any greater detail what was actually being delivered? 10:38 10:38

A. No, the vehicle for monitoring would be to the routine performance meetings between the Health and Social Care Board and The Trusts.

48 Q. Okay. 10:38

49 Q. DR. MAXWELL: Can I just ask, but there are metrics so waiting times would be a classic metric of performance of the contract. Is there a central list of the quantitative metrics that were measured as part of the

commissioning process?

A. Yes. There is a significant volume of information which has been provided by The Trusts to the Health and Social Care Board.

50 Q. DR. MAXWELL: But is there a minimum data set that they are required to return in relation to the contract? 10:39

A. Yes, and that's something which can be provided to the Panel, sorry, to the Inquiry, if helpful.

51 Q. MS. KILEY: And those records would be available then from 2009 all the way through the Health and Social Care Board's life, is that right? 10:39

A. Yes.

52 Q. But it only commenced in 2009 with the establishment of the Health and Social Care Board?

A. I'm not aware of the metrics that were used in the Health and Social Services trusts but, again, I am more than content to go and try and identify that information for The Inquiry about what was reported with regard to performance management to the Health and Social Services Boards prior to 2009 and we can provide both to the Inquiry at subsequent stage. 10:39

53 Q. Okay.

54 Q. CHAIRPERSON: This is purely for clarification so that I understand something. Dr. Maxwell asked you, are there metrics, she said waiting times would be classic metric of performance, or is there a central list of the quantitative metrics that were measured as part of the commissioning process. 10:39

Now, are you saying that performance is part of the commissioning process or does it run, as it were, in parallel with it but separate to it?

A. It would be part, my understanding is it would be part of the commission process that there would be metrics which would set out, for example, waiting lists, waiting times, a number of indicators which would be considered by the Health and Social Care Board with The Trusts through regular meetings where they would look at the metrics that were made available by The Trust and where there is improvement that is required, improvement would be identified and taken forward to drive up quality going forward, so it would be central to it. 10:40 10:40

55 Q. CHAIRPERSON: I understand that, but does it affect the commissioning for instance for the next year, what services are commissioned or how they are evaluated? 10:40

A. Yes, because the commissioning arrangements would evolve from one year to the other taking into account the performance. 10:41

56 Q. CHAIRPERSON: Right, so that is how in effect they feed into the commissioning process?

A. Yes.

CHAIRPERSON: Right, I just didn't understand that. Thank you. 10:41

57 Q. MS. KILEY: Just sticking with commissioning, Mr. Whittle, in your statement you also refer at paragraph 3.342 to five local Commissioning Groups. Can you explain to the Panel a little more about the role of

the local Commissioning Groups?

A. Yep.

58 Q. You deal with this at paragraph 3.342 and there you say five local Commissioning Groups were the HSCB regional arms for engagement with community interests and working with a range of partner organisations in the commissioning of care services. But I am just wondering can you elaborate any more on that about what their actual role was and how that fed into the Board? 10:41

A. Yes, if I could ask if we could bring up page 3045. This will be the Terms of Reference for the local Commissioning Groups which were established in the Health and Social Care Board standing orders. 10:42

59 Q. This will come up on your screen shortly, we are just working on that. This is your exhibit? 10:42

A. If you go down to 1.2. This is Exhibit BW16. You'll see there...

60 Q. So this is actually one of the Board's standing orders, is that right?

A. Yes: 10:42

"The role of the local Commissioning Group are the point of local leadership in commissioning Health and Social Care.

10:42

The Framework of the Board's commissioning plan will articulate the vision, purpose and control of the commissioning function for local Commissioning Groups in order to deliver effective and efficient

commissioning in their areas. They will need to understand, interact and respond, and adapt their own situation and external environment.

Each LCG will be required to contribute to the Health and Social Care Board's strategic planning process to improve health and well-being and provide high quality health outcomes and reduce inequalities to its local population." 10:43

10:43

The LCGs were a Committee of the Health and Social Care Board and they were effectively the local commissioning arrangement that would bring together a number of staff from the local Health and Social Care Trust. If you scroll down a bit further you'll come to the membership. 10:43

If you go down a bit further you will see there the four GPs, pharmacist, dentist, local elected representatives and the community voluntary sector, employees of the Health and Social Care Board and Public Health Agency. You see the membership there with a particular role with regard to local commissioning. 10:43

61 Q. What was the relationship like then between the local Commissioning Group and the full Board, how often was there feed-back between the two? 10:44

A. The local Commissioning Group Chairs would be in attendance at the Health and Social Care Boards' Board

meeting, each meeting.

62 Q. And how regularly did that meet?

A. The Health and Social Care Board would have met in the region of eight times per year.

63 Q. So are you saying eight times per year then the Health and Social Care Board would have received a report from each of the local Commissioning Group? 10:44

A. The minutes of the local Commissioning Group meetings would have been tabled at Health and Social Care Board, Board meetings. There are also a number of officers of the Health and Social Care Board, senior managers effectively, who would have had direct responsibility in terms of working closely with the local Commissioning Group Chairs to ensure that the work they take forward was aligned to the commissioning plans within the Health and Social Care Board. 10:44 10:45

64 Q. How did that relationship actually effect the services which the Board was commissioning, so for example, if the local Commissioning Group identified a particular need in terms of local commissioning, would the Board be able to respond to that, I suppose what I am getting at, aside from just the reporting and receiving of information, how did that actually effect what the Board commissioned? 10:45

A. The local Commissioning Groups would have been influential with the Health and Social Care Board in terms of setting the commissioning plan for each year and there would have been close working relationships as the year went on in terms of the delivery of 10:45

services and local communities.

65 Q. DR. MAXWELL: Can I just ask then, the local Commissioning Group didn't have any delegated authority, it was advisory to the Board?

A. If I could maybe just scroll up on the Terms of Reference I think that might be covered at the start of that from memory. 10:46

So, on the screen that's before us there it sets out the aims of the local Commissioning Group. My understanding is that those aims, in terms of improving well-being and planning commission and health care in securing the delivery to people in their area would be delegated from the Health and Social Care Boards who didn't have an authority in their own right, although local Commissioning Groups were established in - I'm not sure in it is primary legislation or regulations, but they were established. 10:46 10:46

DR. MAXWELL: I'm not sure that that tells me they had any decision-making authority, that they would come together, discuss, make recommendations, advise the Board, but ultimately the decision to take action, and particularly to fund it, would lie with the full Board rather than the Committee of the Board which the LCG is. 10:47 10:47

A. Might I suggest, Dr. Maxwell, the information with regard to the LCG is that would be established on the Terms of Reference. I am more than happy to try and clarify that in terms of what the decision-making

arrangements and authority was and to furnish The Inquiry with that at a subsequent stage.

CHAIRPERSON: Thank you.

66 Q. MS. KILEY: Mr. Whittle, that's their commissioning role. Did the LCGs have any role in performance management? So would they have been reporting on issues arising and the delivery of the contract, is that the sort of thing that they would have reported back to the Board? 10:47

A. Might I suggest that I would clarify that alongside the other information with regard to LCGs, because it is not something which I am over at this stage, so apologies for that. 10:48

67 Q. Okay. I want to then; you've referred throughout our discussions on commissioning to commissioning plans. And you do explain a little more about that later on in your statement, so I want to ask you a little bit about that. Deal with this paragraph 3.61 to 3.63 of your statement which is at page 22. So, is it right to say that in terms of the commissioning of Learning Disability Services the Regional Board was required to produce a commissioning plan annually, isn't that right? 10:48 10:48

A. Yes, that's correct.

68 Q. Can you explain, you have provided examples which I will turn to, but if you are able to, can you explain to the Panel what a commissioning plan is? 10:48

A. The commissioning plan is the framework, it's actually...

69 Q. You do provide some examples and I am going to turn to those, Mr. Whittle, but what I am really getting at now is: Can you explain what it's purpose is, what is the intent of a commissioning plan?

A. The commissioning plan is the Health and Social Care's Board's response to the commissioning plan direction established by the Department of Health which sets out the strategic objectives, the priorities which will be delivered by the local Health and Social Care Trust to deliver Health and Social Services with the intention of improving the health and well-being of the population, so effectively the plan for the year for the Health and Social Care, an interpretation of the commissioning plan direction which has specific arrangements and goes slightly beyond that in terms of the Board's commissioning arrangement for the population of Northern Ireland based on the performance that we discussed earlier on and based on the performance and the intention of the Health and Social Care Board to meet population needs. 10:49 10:49 10:50 10:50

70 Q. So the commissioning plan direction comes from the Department. Is it fair to say then that it is more of a strategic document and then the Health and Social Care's Board's commissioning plan sets out the Board's intention of how it will meet the directions that come from the Department of Health, is that a fair summary? 10:50

A. That's correct, and going to our earlier point the service budget agreement is read alongside the commissioning plan which will give the metrics of what

will be delivered. So you have the CPD at the high level, you have the commissioning plan which is the strategic direction, and the service budget agreement then is the quantity of what would be provided under contract.

71 Q. Yes, so they all work together. I am conscious that we are talking about the Regional Health and Social Care Board again, so that's only established in 2009. Were commissioning plans issued by the Legacy Board, do you know? 10:51

A. I believe they were but I will clarify that.

72 Q. And you do refer in your statement to extracts of the commissioning plan, it is worth looking at some of those. You have been able to identify or provide three commissioning plans that refer to Muckamore Abbey Hospital. I am not going to go through them all, the Panel has them. But just by way of example, if we could look at the commissioning plan for 2011, 2012. It appears at page 3,421. So that's on your screen in front of you. The commissioning plans are jointly authored we can see at the bottom by the Health and Social Care Board and the Public Health Agency. Can you tell the Panel any more about that joint role, Mr. Whittle? 10:51 10:52

A. Yes, the commissioning plan needs to be approved by both the Health and Social Care Board and the Public Health Agency. One organisation could not approve the plan on it's own, it would have to have the joint approval of both to be established. 10:52

73 Q. In terms of who takes the lead in drafting the commissioning plan, is that the Health and Social Care Board?

A. The Health and Social Care Board would take the lead in the drafting of the commissioning plan but it will be done in full partnership with the Public Health Agency in terms of their contribution to the sections within it and could not be signed-off or approved without the approval of the Public Health Agency's Board. 10:52

74 Q. Okay, and if you could just scroll down to the next page please. You can see the Table of Contents and there are a number of topics within the commissioning plan. There is specific learning disability section. It commences at page 3,540, if we could turn to that please and if we could scroll out so we could see that whole page please. 10:53 10:53

So, this is a particular section within the plan that deals with mental health and learning disability provision and you can see that there is a summary of the section there. If we could scroll down to page 3,542 please, two pages down. If we just pause there, you can see the topic: 10:54

"Targets and Priorities. Trusts must work in partnership with the Commissioner to develop a major program of reform, modernisation and standardisation." 10:54

And then there is a Mental Health Services section and

beneath that you can see in bold within "Learning Disability Services", the key strands will be: Re-settlement, day services, improve physical and mental health and family support. It says the Board and the PHA will work with The Trust and other stakeholders to ensure that the following targets and standards are delivered in 2011, 2012.

Scroll down there, you can see the first bullet point, just pause there please. You can see there are then a series of bullet points that set out various targets that must be achieved, so for example, that first one:

"No patient waits longer than 13 weeks to assessment and commencement of treatment." 10:54 10:54 10:55

And you can see there follows a number of other targets. I wanted to ask those are specific targets contained within the commissioning plan and that sort of information is typical of what is contained within a commissioning plan, is that right? 10:55

A. That's right.

75 Q. So just generally then, can you explain how the Health and Social Care Board monitors the work the Trusts towards achieving those targets throughout the life of the commissioning of the services? 10:55

A. So, if you take by way of example the second bullet point there, 31st March 2012 to re-settle at least an additional 45 long-stay patients with learning

disability to an appropriate place in the community compared to the end of March 2011 figure. That would be monitored through the performance meetings that I referred to earlier between the Health and Social Care Board.

CHAIRPERSON: I don't think the microphone is going to be coming over on the feed. Can you just move it away a little bit, try that.

A. Is that better?

CHAIRPERSON: Apologies to interrupt you, Mr. Whittle.

76 Q. MS. KILEY: We will come to the end of this section and see how we manage, Mr. Whittle, and then if we need to make adjustments we will. I had asked you about how the Board monitors those targets, you were referring me to the performance?

A. Referring to the performance management meetings that I had referred to in my earlier evidence, there would be statistical returns which would be provided by the Health and Social Care Trusts to the Board and those would be monitored and then any deterioration trajectory that would be expected would be discussed at the performance meetings on an ongoing basis.

In addition to that, there would be arrangements which would be put in place to, for example, to improve community services. Elsewhere in the commissioning plan typically you might find targets with regard to for example, improving day opportunities or direct payments or other arrangements which could improve

community services, but that would form part of the day-to-day and month-to-month working relationship between the Health and Social Care Board and Health and Social Care Trusts with regard to the targets that are established here. 10:57

77 Q. And what action could the Board take if, through those sorts of meetings the Board became aware of issues and perhaps thought that a target was not going to be met, what powers did it have to try and ensure that the targets were met? 10:57

A. So the first thing that it could do would be to raise the issue with the Trust and to require improvement to be made and monitor that improvement. If there was still no improvement made after raising and requesting it, the Health and Social Care Board could bring that 10:58 issue to the Department of Health, the Department of Health, and you heard this through Mark McGuicken's evidence --

MS. ANYADIKE-DANES: I can't hear this at all, it is a very important question, I apologise. 10:58

CHAIRPERSON: Okay.

MS. KILEY: I think what we will do...

CHAIRPERSON: We might take a break. I'm sorry, this is important evidence and it is not your fault at all but we need to get the microphone sorted. It is a bit 10:58 earlier than we would normally, but we will take a bit of a 10-minute break now.

MS. KILEY: We will work on that, thank you, Chair.

CHAIRPERSON: Apologies, thank you. 10 minutes.

THE HEARING RESUMED AFTER THE SHORT ADJOURNMENT, AS FOLLOWS:

CHAIRPERSON: I gather everything has been tested and it is a bit better. What we'll probably do is, we'll take a slightly early lunch because otherwise I think the next haul is going to be an extremely long one, but about twenty-to-one or a quarter-to-one we can probably stop. 11:18

78 Q. MS. KILEY: Yes. Thank you. Mr. Whittle, just to recap on where we were before we took a break: We were discussing the commissioning plan and we had looked at some of the targets that were set out in the example commissioning plan that we looked at for 2011, 2012 and you refer to the performance management meetings. I had asked you what action could the Board take if it looked like a target wasn't being met. So can you go over that last bit again for us please? 11:18

A. Yes, thank you. So the first action that the Health and Social Care Board could take would be to raise the issue with regard to the under-performance of the particular target with the relevant Trust. In raising that, that may result in there being action required of the Trust to put in place alternative arrangements or to expedite the steps they are taking to achieve the target, or they might indeed be actions which is required on behalf of the Health and Social Care Board. That could be investment or some other issue which the Board needs to take. If the issue was actually a 11:18 11:19

performance issue with the Trust not doing something that it should be doing, the Health and Social Care Board would have recourse to raise the issue with the Department of Health.

11:19

The Department of Health, and I think you heard this just before we broke, I think we heard from Mark McGuckin's evidence there are sponsorship arrangements within the Department of Health and that there are arrangements with the Department of Health to hold Trusts to account to their meetings with the Chair and Chief Executive and Senior Leadership Team.

11:19

So, if the issue could not be resolved by the Health and Social Care Board it could have been escalated to the Department of Health who could raise that with the Trust and then beyond that there will be layers of escalation within the Department of Health, it could be raised at - I forget the name of the accountability meetings, but there are two twice-yearly accountability meetings between the Department of health and The Trust. Likewise, it could be raised between the Permanent Secretary if it required further explanation and the Chief Executive, or ultimately, between the Minister and the Chair in terms of escalation.

11:20

11:20

So by that tiered and measured escalation an issue could be brought from the Health and Social Care Board all the way up to the Minister and the Chair of The

Trust that wasn't performing.

79 Q. And you've referred there to arrangements by which the Board can raise it with the Trust on one level and potentially escalate it to the Department on a different level. Did the Board itself have powers to impose any penalty on The Trust? 11:21

A. I do not believe so, I'm not aware of any powers, but it is certainly something which I can check in terms of my own memory, but from memory I do not believe that the Health and Social Care Board did have powers. 11:21

80 Q. In terms of raising it; so is it fair then to say that the highest power, or the most grave power, that the Board had was essentially to raise it with the Department, is that the most it could do, if for example, it did consider there was an issue? And you have explained that the first step would be to raise it with the Trust. But if it hadn't been resolved at that level, is the most then that the Board could have done to raise that with the Department? 11:21

A. On an operational level a day-to-day level that would be correct. There are things that the Health and Social Care Board could do by way of financial arrangements that it has in place. So it could make a decision to retract funding from one Health and Social Care Trust and apply that funding to a different Health and Social Care Trust, it could put steps in place to change the provider of an organisation. That would not be something which would be done in isolation by the Health and Social Care Board, but would have been done 11:21 11:22

in conjunction with the Department of health.

81 Q. Are you aware of whether the Health and Social Care Board ever did raise issues in respect of service provision at Muckamore Abbey Hospital with the Trust, first of all, and also with the Department? 11:22

A. Certainly in terms of raising issues with regard to performance with the Health and Social Care Trust, that would be something which would have been routinely raised at the performance management meetings and that would be referenced in the minutes that we said earlier 11:23 on --

82 Q. Yes.

A. ...that we would share. Those, I would be confident that there would be records between the Health and Social Care Board and the Department which was 11:23 identified at the deterioration of performance and, again, if helpful to the Inquiry, those could be provided to the Inquiry.

83 Q. Yes. Are you able to say any more about the method of that reporting to the Department, is there a formal 11:23 mechanism or a procedure around that?

A. It's actually not something which I have covered in my evidence and I anticipate the answer to that is yes, but rather than to speculate I would rather provide the precise information to the Inquiry, so something I will 11:23 clarify and come back to the Inquiry in relation to.

84 Q. Okay, thank you. I'm not going to go through all of the examples of the commissioning plans that you provided. I wanted to pick-up on a point you made

about the 2019, '20 commissioning plan and you say that this is referred to as a "Draft Document" but, you also then say it's actually the final version and the reason is because there was no Minister in Post to formally approve it, so that's why it is formally marked as "Draft" but is actually final.

I wonder if you could assist the Panel in explaining any more about the HSCB's experience of the impact of a lack of Minister in position. For example, what ways has the lack of a Minister during the periods in which the default government hasn't been sitting affected the service or the commissioning arrangements which the Board has been putting in place? 11:24 11:24

A. The lack of a Minister or otherwise is not something which I anticipated I would be required to cover under today's evidence, so I would prefer to take a Departmental view in terms of colleagues within the SPPG and others and to come back to the Inquiry on that point. It is nothing something which I prepared for today. 11:25 11:25

85 Q. Okay, but are you able to even say in practical terms, in terms of the role that the Board was carrying out, is it different whenever a Minister is in place, is it easier, is there any real difference between the role that you carry out when a Minister is in place and when a Minister is not in place? 11:25

A. Well, on a general point all I can say is that when a Minister is not in place then there are arrangements

put in place with Permanent Secretaries and Deputy Secretaries and others to ensure that good governance continues and that we utilise those arrangements, as is the case across Northern Ireland when there is no Minister in place in any particular Government Department then that can cause difficulties, but beyond that I really wouldn't want to speculate today.

86 Q. Okay. So, moving on then from the Board's commissioning plan, you also refer to The Trust's response to that commissioning plan and you say that The Trusts create a Trust delivery plan. You dealt with this at paragraph 3.66 of your statement. I don't need to take you to that in detail, but just to clarify some aspects, is The Trust document a document which is also produced annually? 11:26

A. Yes it is.

87 Q. And you reference an approval process in respect of that, can you tell the Panel any more about whether the Board's process for approval of those documents?

A. Apologies, I will have to clarify that, other than in very general terms that the Trust delivery plan is submitted or was submitted to the Health and Social Care Board for approval, but beyond that I don't have detail today.

88 Q. Okay. 11:27

A. But I am happy to clarify what the form of that approval process was and to provide that information to the Inquiry.

89 Q. And The Inquiry may be interested just in the

procedures around the approval process and what type of scrutiny the Board provided to those plans.

Finally then in respect of commissioning, I just want to end by asking you about the present day. There have been some changes, or are some changes afoot, and you refer to this at paragraph 3.50 of your statement, you say: 11:27

"Following the dissolution of the Health and Social Care Board and the transfer of functions to SPPG in the DOH, the commissioning processes which were in place when the HSCB existed are still being utilised with a review to reform." 11:27

11:28

You then at paragraph 3.51 refer to a new integrated care system that's being developed for Northern Ireland. Are you able to tell the Panel any more about that new system being developed and what stage it's at and when it is anticipated that that will be in place? 11:28

A. Yes. Sorry, can I just clarify, do you want me to also refer to the commissioning arrangements that were in place from 2019 or 2020 onwards, or just to the new future commissioning arrangements?

90 Q. Give me 2019 onwards, if 2019 is different to what we have just discussed then explain that first and I will bring you back to this element then? 11:28

A. So the commissioning plan for 2019/20 was rolled on to the following year and that was because the Covid

Pandemic caused a pause in the commissioning plan process. In March 2020 when Covid hit a decision was taken by the Department of Health to roll over the '19, '20 commissioning plan direction, so therefore a commissioning plan was not produced.

The rationale for that was that it enabled the Health and Social Care Board and the Public Health Agency to flexibly and agilely respond to the Pandemic whilst maintaining services. So in lieu of the commissioning plan a regional surge framework was developed and subsequently published in October 2020 and, again, that is not in my evidence exhibited but can be made to the Inquiry, if helpful.

A re-build plan was put in place following the first year of Covid to bring the health and social care back to the level of activity that was in place prior to the Pandemic and to bring back the activity to the same level or attempt to bring activity back to the same level that was in place in year 2019/20.

91 Q. They were responses to the Covid Pandemic and they were practical and operational responses, but there was no actual change to the commissioning structures, isn't that right at that time?

A. No, no, that is right, albeit the commissioning plan process was paused.

92 Q. Pause essentially --

A. Because there was no commissioning plan direction in

subsequent years and that was put in place for the Covid planning arrangements, as agreed with the Department of Health at that stage. Looking to the future then, there is the intention to develop an integrated care system for Northern Ireland which will be a new planning model for Northern Ireland which will - the intention is to bring forward a closer alignment between primary care, Trusts and the voluntary sector in population, need, assessment, and planning. That is currently being developed, being worked up between the Strategic Planning Performance Group and policy colleagues within the Department of Health, and subject to a future Minister's decision there will be a new planning model established, which may or is likely to include a number of structures including Area Integrated Planning Boards as a replacement for local Commissioning Groups that we referred to earlier. But at this stage that decision has not been taken, subject to a Ministerial decision. 11:31 11:31 11:31

93 Q. Are you able to assist the Panel any more with the rationale behind that change, why was it considered that it's necessary to make that change? 11:32

A. My understanding is that there would be a desire to ensure that the planning arrangements are improved from that which were in place when the Health and Social Care Board was dissolved. Again, my understanding is that the point that that was announced by the Minister with regard to the closure of the Board was with a view to improving the commissioning arrangements for 11:32

Northern Ireland into the future and the new integrated care system would be the Department's response to improving those services for the future.

94 Q. Is it implicit in that, that it was considered that the commissioning arrangements that did operate in the Health and Social Care Board were deficient in some way? 11:33

A. I think it's implicit within that that they are in need of reform and improvement and that is what has happened. The first step of that has been to close, or rather to dissolve the Health and Social Care Board to ensure that there is a closer alignment to the Department of Health, and the second stage of that would be the development of a new integrated planning system which will work more closely with partners in primary care, Trusts and voluntary community sector and service users to ensure that a planning model for Northern Ireland is fit for the future years ahead. So there is very much an intention to improve services through this, with the closure of the Board being the first step of that, and future planning model being the second step of that. 11:33 11:33

95 Q. Yes, okay. Thank you Mr. Whittle. I am going to move on to the next topic which is Module 2H and you deal with this at paragraph 4.1, page 26 of your statement where you explain the structures in place to promote quality of care at Muckamore Abbey Hospital. 11:34

We have touched on this a little whenever we've

discussed performance management and at paragraph 4.2 of your statement you set out eight, what you describe as "processes" that were operated by the HSCB to promote quality of care at Muckamore Abbey Hospital.

11:34

So if we could just scroll down on the screen please so we can see the bullet points. Thank you. If you just pause there. So we can see the eight bullet points, the eight processes which you have set out:

11:34

"Performance management, service and quality improvement, Delegated statutory functions, complaints, legacy adverse incidents. Serious adverse incidents, including interface incidents. Early alerts, safety and quality alerts."

11:35

And you then go on to explain each of the processes in detail in how they contribute to the promotion of quality of care. I want to just take a bit of time to go through each of those. The first is performance management, which we have touched on. You've answered some questions more generally about performance management, I won't ask you to go over there. But one of the things that you mention at paragraph 43 is that re-settlement targets were withdrawn at the end of March 2015 which was the target date for the completion of the re-settlement programme. You say that it was replaced with an indicator of performance during 2015, 2016 and, again, you have already referred to the

11:35

11:35

different, the processes there between targets and indicators of performance.

But can you tell the Panel any more about the rationale for the removal of the re-settlement target in 2015, because the Panel has heard, and we know that the re-settlement targets weren't actually reached and achieved by then, so are you able to say any more about why they were removed? 11:36

A. My understanding is that a target, once established, is expected to be delivered. So the very fact that they weren't met was the rationale for why they were replaced by an indicator for performance, one wouldn't retrace back to say 'here's a different target or a new target' the target was to do something by a date. If that is either achieved or not achieved as a binary outcome, in the event that it is not achieved, then there is a switch to the indicator of performance which is the vehicle by which government, the Department, would then set the expectations for the performance going forward. 11:36 11:36 11:37

96 Q. And in reality, are you able to say anything more about how that affected the services which the Board commissioned, if at all? So it had targets initially and those targets weren't met, so presumably the indicator of performance then was to try and drive forward re-settlement, is that right? 11:37

A. That's right, but my view on this would not be that an indicator of performance is less than a target. It's a

different way of expressing what Government required to be undertaken. So initially there was a target to do something by a certain date, that was not achieved and that then became an indicator of performance. I would not anticipate that an indicator of performance would have caused any diminution in terms of the Board's rigor or The Trust's desire to achieve the indicator of performance.

97 Q. We've touched on targets and indicators of performance. You have also referred the Panel to performance management meetings between the Boards and The Trusts, are there any other ways in which the Board exercised its performance management function, is that essentially a summary of how it was done?

A. That's essentially an explanation of how it was undertaken.

98 Q. The second process that you refer to then is "Service Quality and Improvement" and you deal with that at paragraph 4.4 onwards. Paragraph 4.4 to 4.10, again, I am not going to go through it again in great detail but I wanted to ask you to clarify some matters. At paragraph 4.6 you refer to a "Service Improvement Team" which was set up in 2014 and you list the functions of the Service Improvement Team. But are you able to say any more about how that Service Improvement Team worked in practical terms, I'm thinking particularly about how it liaised with the Trusts and how the information received from any such liaison fed back into the Board?

A. Yes, I've reflected on this, these paragraphs, since I

wrote my statements and on hearing and reading the evidence of other witnesses, and whilst I have given written evidence here with regard to the Service Improvement Team that was in place, my reflection on that is that largely the Service Improvement Team had focused on Mental Health Services rather than Learning Disability Services.

However, I am minded of the evidence that I've heard elsewhere with regard to the Learning Disability Service Framework and I've referenced in this evidence the Learning Disability Service Model. With regard to Service Equality Improvement I might, if you are content Ms. Kiley, to give an explanation of how the Health and Social Care Board took the Learning Disability Model and the Learning Disability Framework to improve quality over this period. 11:40 11:40 11:40

99 Q. Yes, please.

A. So, I've heard - The Inquiry will have heard evidence from previous witnesses about the decision to stand-down the Learning Disability Service Framework. The Learning Disability Service Framework had been; sorry, had been introduced by the Minister, I think it was Minister Poots in 2015 and it established 34 standards and associated KPIs. At that stage the Health and Social Care Board had appointed a Learning Disability Service Framework Co-Ordinator and action followed to establish a baseline and to drive improvement against the Learning Disability Service 11:40 11:41

Framework Standards. This improvement sat outside of the Health and Social Care Board's formal performance management meetings that were referred to earlier on and had been led at the time by the Directorate of Children and Social Care, the intention being to improve the quality of services against the Learning Disability Service Framework. 11:42

This is, incidentally, referenced in the relevant Health and Social Care Board commissioning plans and also The Trust delivery plans of the time. 11:42

A decision and evidence was presented to the Inquiry previously to stand-down Learning Disability Service Frameworks in line with other service frameworks across other service areas in 2018. I understand, on reflection of hearing Roy McConkey's evidence, that he had referred in his evidence that Standards 26 and 27 of the Learning Disability Service Framework were not used. To remind The Inquiry, Standard 26 refers to local support for challenging behaviour. Standard 27 refers to people with learning disabilities who came into contact with the criminal justice system receiving appropriate support. 11:42 11:43

I am advised that every Standard was considered by the Health and Social Care Board, including Standards 26 and 27 and the Health and Social Care Board has documentation that relates to this consideration which 11:43

can be made available, will be made available to the Inquiry, and apologies for not making that available in my statement, but it was only after hearing the earlier evidence that I realised the importance of this.

11:44

After the decision was taken to stand-down the Learning Disability Service Framework --

100 Q. Can I just pause you there, Mr. Whittle, because just to remind those listening, that decision was taken by the Department of Health, isn't that right, that's not a Board decision? 11:44

A. Yes, my understanding is that decision was taken at the stage by the Chief Medical Officer's Department.

101 Q. The Inquiry has heard from Mark McGuckin about that matter, is that right, is that what has prompted your consideration of that. If you continue then. 11:44

A. So after the decision to stand-down the Learning Disability Service Framework was taken there still remained a desire to build on the work of the Learning Disability Framework and to develop a Learning Disability Service Model. This was in part because the baseline assessment of the Learning Disability Service Framework had showed that services had developed organically and differently by Trust area, and that there was a need to develop a uniform single model for Northern Ireland for Learning Disability Services. 11:44 11:45

This consideration coincided with funding that became available from central Government with regard to the

competence and supply arrangements with the former Government with Northern Ireland political parties and funding became available which was utilised to develop a Learning Disability Service Model.

11:45

That Learning Disability Service Model titled "We Matter" was formalised and the quality, service and improvement methodologies of the team that I referred to in my original evidence, had informed the way in which that Learning Disability Service Model had been established. 11:45

The Service Framework, as I said, had set standards but there was still variation by Trust, so the model that was needed to give a regional framework, the Learning Disability Service Model sets out a pathway of care firstly. Secondly, how people will stay independent. And thirdly, community assessment and rehabilitation and treatment arrangements. And it sets out a number of key Ambition Statements from one to six including meaningful life and citizenship. Secondly, "health and well-being. Thirdly, supporting people at home. Fourthly, life changes. Fifthly, carers and families and lastly, specialist assessment and treatment. Each of those six domains are supported by established outcome measures about how those will be measured into the future. 11:46 11:46

The Learning Disability Service Framework, and you will

have heard from Mark McGuckin in this space, has been submitted to the Department and after some further work with regard to the costing of that, is now being taken forward to an action plan that has been established by the Department of Health from January this year going forward.

So, whilst my original evidence, or rather my written evidence, had given narrative with regard to the development of a Service Improvement Team, hopefully the oral evidence I have just given has explained how the process of moving from the Service Framework to the Learning Disability Service Model was established as a service and quality improvement initiative. And the steps that were set out in my paragraph 4.7 on page 28 through to 29 of my statement, set out the sorts of methodologies that a Service Improvement Team would have utilised, so those would be to provide objective analysis, to develop robust data, to undertake diagnostic work, to support the development of safer practice and so on. Those types of arrangements were the very arrangements which informed the work which took place with regard to the development of the Learning Disability Service Model.

So hopefully that assists The Inquiry with an indication of how the Health and Social Care Board endeavoured to drive quality over this period.

102 Q. In terms of the model which you have referred to, I

think you have actually exhibited that in any event, is that the model which you refer to at paragraph 4.9 of your statement as the draft Learning Disability Service Model?

A. Yes, that's correct. 11:49

103 Q. That is exhibited at your Exhibit 29. What is it's current status? You refer there to submitting it to the Department, has it yet received formal Departmental approval?

A. It's received approval to be worked up to the next stage. So there is a work stream which has been established to develop that. Obviously with anything of this nature it will require Government's decision, either at Permanent Secretary level or Ministerial level in terms of the execution of it and the costs behind it. But certainly, it has now been taken forward to the next stage in conjunction with colleagues in Mark McGuckin's team and my team. 11:49 11:49

104 Q. How is it that the Board envisages that having that in place, particularly where there is no learning disability framework, will help the Board improve service quality? 11:49

A. My hope and aspiration in this will be that it will create a single model for Northern Ireland which will be a quality model. We have heard evidence at this Inquiry, and I believe from my own experience that the position currently across Northern Ireland is not consistent, different Trusts have different arrangements in place. A single Model will enable one 11:50

Model for Northern Ireland. It will also ensure that we have the appropriate arrangements in place, whether it is assessment and treatment in hospital, or whether it's community assessment, rehabilitation treatment or whether it is support for people at home. 11:50

Those different layers, many of which go back to the early ambitions of Bamford and Equal Lives follow through as a theme in terms of the arrangements that are in place. In my mind, the way that I have 11:50 reflected on this, I can see a thread between Bamford, Equal Lives, the Framework, the Learning Disability Service Model, all of which is good in the trajectory which was set out in the original ambition and aspirations behind Bamford. 11:51

105 Q. Is it fair to say then that the model, whenever it is in place, will provide the baseline, a regional baseline essentially for which service quality can be assessed, is that a fair comment?

A. Yes. I think it's also fair to say the Service 11:51 Framework did provide a baseline at that stage. What it established is that that baseline was not equitable across Northern Ireland, what this will give us will be a model with discrete outcome measures which will be more, what I would hope will be more than just the 11:51 quantitative data, but actually outcome in terms of how people's lives are made better, how health is improved for individuals through the implementation of the model if and when it is implemented.

106 Q. Yes, because it is still at draft stage. Are you able to assist the Panel with whether - you've referred to the Framework and we know that it has been withdrawn, did the withdrawal of the Learning Disability Framework adversely effect the Board's ability to assess service quality and improvement?

A. My personal view on this is that, on reflection, I think the Health and Social Care Board was assisted by the timing with regard to the competence and supply of funding that was made available, which meant that the work that had been taken forward with regard to the Framework was not lost and was able to be developed through the Learning Disability Service Model. So I think that was fortunate in terms of making best use of the circumstances that the Health and Social Care Board operated in at the time.

107 Q. DR. MAXWELL: Can I just ask about the model: So we've heard a lot of focus, rightly so, on re-settlement and community services, but there are still people in in-patient care and there will always be assessment in treatment even if there is a small number. Does the model and did the framework actually address quality of in-patient Learning Disability Services?

A. The model covers both assessment and treatment of in-patient and also community assessment and treatment. So the aspiration of the model is that it will cover not just the small amount, I don't mean to be dismissive, but the smaller numbers that are looked after in hospital care. It has to include the whole

model in terms of where people live in the community but will cover both.

DR. MAXWELL: But it does include hospital, given the subject of this Inquiry is in-patient care.

A. Absolutely, and part of this will dependant on other measures that are in place at the time. So for example, The Inquiry will have heard evidence previously with regard to the ongoing to the public consultation with regard to the closure of Muckamore Abbey and depending on that decision, there will be potential opportunities under a new model to invest funding which is currently tied, related to the provision of in-patient care, to a different model of assessment and treatment and a different model of community and home support. 11:53 11:54 11:54

DR. MAXWELL: Thank you.

108 Q. MS. KILEY: Thank you for that, Mr. Whittle. I am going to move on to your third process which is "Delegated Statutory Functions" and you deal with that at paragraph 4.10 onwards. And, again, you provide a significant narrative about the delegated statutory function reports. I am not going to ask you to repeat all that, but are you able to explain in brief terms what the purpose of a delegated statutory function report is? 11:54 11:55

A. Yes, and the purpose of the delegated statutory functions report is to put in place a performance arrangement so that the Health and Social Care Board can be assured that the Health and Social Care Trusts

are compliant with their legal duties and powers across a range of different programs of care, not just with regard to learning disability, but across the gambit.

109 Q. Okay. So it's drafted by The Trust and submitted to the Board, is that right? 11:55

A. Yes.

110 Q. And you refer in your statement to the position between 1999 and 2007. You say that each Trust submitted an annual report to the relevant geographical Legacy Board. Are you aware of the processes which were in 11:56 place for the Legacy Boards to scrutinise those reports?

A. They have largely, similar to the arrangements that would be in place since 2009, so each Health and Social Services Trust, or after 2009 Health and Social Care 11:56 Trust, completed a prescribed template to set out their performance in relation to statutory functions.

Whilst there were four reports, which were utilised under the Health and Social Services Boards, they used 11:56 the same template across the four Health and Social Care Boards, each of the 18 Trusts at the time. This report, both prior to 2009 and post-2009, was submitted to the Health and Social Care Board, or Health and Social Services Boards. It was reviewed by the Health 11:56 and Social Services Boards, or the Regional Board, essentially by the staff within the Children and Social Care Directorate, so largely by staff who would be registered social workers.

Since 2010 a composite report had been prepared by the Health and Social Care Board for all of the Trusts on the issues which arises in the five Trusts' reports which is submitted via the Health and Social Care Boards' Board to the Department of Health. The Department of Health have responsibilities to review the composite report. I should say prior to the composite report, the former Health and Social Services Boards would have sent The Trust reports directly to the Department, but there have been a continued line of reporting via the Legacy Boards or the new Board to the Department. 11:57 11:57

The Department of Health have responsibilities to review the information that's provided and, where appropriate, to share with the Departments of Health Departmental Board and to raise any issues with Health and Social Care Trusts as part of it's arm's length body accountability arrangements where it has been brought to the attention of the Health and Social Care Board. 11:58 11:58

111 Q. Okay?

A. Sorry if I was long-winded.

112 Q. No, I just wanted to make sure that I have it right. So is the position this, that The Trust submit the delegated statutory function reports to the Board, the Board has a process of analysing those and it is through that process that it creates the composite 11:58

report which the Board then sends to the Department, is that right?

A. That's correct. The only thing I would add to that and in addition to the analysing of it, there would be face-to-face meetings with the Health and Social Care Trusts by the Health and Social Care Board and there would be a process of action planning of the issues that are identified.

113 Q. Yes, and I want to just focus in on that a little bit more because you refer to that at paragraph 4.21 of your statement. If you could call that up please, it is on page 33. 11:58 11:59

So you can see there, Mr. Whittle, you refer to the fact in June each year the Health and Social Care Board meet with senior management from each Trust to review and discuss the findings of their DSF submissions and to agree an action plan to address concerns regarding areas where The Trust was not meeting their statutory functions and you have given an example of that. Just to be clear then, is there always an action plan every year, or is it just whenever the Board considers that there is something that has not been met? 11:59 12:00

A. There would be an action plan every year.

114 Q. So there is always a requirement for that? 12:00

A. Yes. There is an action plan every year, although you will have seen in my evidence that I have referred to the strengthening of the action plan because under the legacy arrangements, and earlier years within the

Health and Social Care Board, the action plan at times was rolled over from one year to the next and it was difficult at times to have a clarity around the actions. So we tried to strengthen that process.

115 Q. Are you referring to the review that took place in 2020? Okay. I am going to come on to that. I just want to focus in on the action plan process for now. It may be worthwhile actually doing this by turning up the example that you have provided. So you have provided the example of an action plan from 2021, it is at page 5468. If we can bring that up please. 12:00 12:00

So, can you see that in front of you, Mr. Whittle, this is the example of the action plan for 2021 and this is for Children's Services and you can see it is entitled "Issue Action Agreed At Meeting in 2020" and then the issue is set out and the progress update. I want to just look at the next page please, it should be the second entry. Yes, see where it says "issue with children with a disability". Can you see that? The box at the bottom of that page, Mr. Whittle? 12:01 12:02

A. I can.

116 Q. So, you can see there that one of the issues that is listed is that:

12:02

"The Trust is working with the Board to address shortfalls and to carry out further assessment of the need to inform commissioning priorities, business cases have been developed in relation to young people who are

delayed discharges from Ivy."

So you can see there that the type of information that is contained in an action plan, using this as an example, is delayed discharge and I appreciate this is for 2021 and this relates to Ivy. But this Inquiry has heard evidence of delayed discharges from Muckamore Abbey Hospital. So would you envisage that if delayed discharges were an issue in any particular period, that that's the type of thing that would have been picked up in an action plan between the Board and the Belfast Trust who were providing the service at the hospital? 12:02 12:03

A. Yes.

117 Q. And presumably then there will be records of whenever that took place? 12:03

A. Yes.

118 Q. And are you able to say whether, from your own knowledge, there were such action plans between the period 2009 and 2021?

A. In terms of my own knowledge, you will know from the introduction that I have only been in post as a Director for two years, but during those two years and the DSF meetings with the Belfast Trust, there have been discussions with regard to delayed discharge and there will be documentary evidence which we can make available to the Inquiry in that regard. 12:03 12:03

119 Q. Okay. And to what extent would issues such as safeguarding, if they arose, appear on an action plan like this? So if for example, the Board was aware of

safeguarding issues in a particular service area, is that the type of thing that would be listed for action in an action plan?

A. The issues that would be listed would be a combination of issues that a Health and Social Care Trust brings in a report to the Board as part of its reporting arrangements, but also issues that professional staff and officers of the Health and Social Care Board would wish to bring to The Trust's attention. So it could be either, issue from Trusts or issues from the Board's perspective. The purpose of the meeting is to enable a discussion to take place with regard to that and then a determination with regard to the actions to be taken forward. 12:04 12:04

120 Q. Yes. And we can see there the actions are set out in the right-hand column in this example. What penalty could the Board impose for a Trust failing to meet a requirement of an action plan? 12:04

A. So in terms of first the box on the right-hand side, just for The Inquiry's knowledge, to be aware that this is not just an annual action plan but there would be a minimum of three meetings between the Board officers and The Trust over the course of the year to look at the issues. 12:05

If the issues are not addressed they can again be remitted to the Department of Health either in the following years delegated statutory functions report or if need be, through correspondence to the Department 12:05

over the course of the year to raise issues. And beyond that it would go back to the arrangements I had previously set out as to how the Department, the arrangements that the Department of Health has in place to hold Trusts to account through sponsorship of arm's length bodies.

121 Q. Just pausing there you refer to meetings between Board Officers and Trust Officers. What level of seniority do those officers hold in each of the organisations?

A. On the Health and Social Care Board side these would be staff who would be employed as social care leads who would be typically on agenda for change, salary scale 8B.

122 Q. And is that a relatively senior level?

A. Sorry, I should explain, yes, that would be relatively senior. Yes, it would be senior management level.

123 Q. Senior management level on the Board side. What about The Trust side?

A. The Trust side then, equally it would be either Heads of Service or Assistant Directors within The Trust who would be involved in those discussions.

124 Q. Okay. Returning then to my original question, it was: What is the penalty that the Board can impose for a failure to meet a requirement of an action plan?

A. I will check the regulations, I don't want to speculate. Typically it would be escalation, however, I believe that there are references in the guidance to being able to withdraw services to Trusts in the guidance which is set out in page 32 of my witness

statement. I'll need to review those in terms of sanctions, so if I might do that outside of the Inquiry and come back with the specific sanctions that are available to us.

125 Q. Yes, and just touching on the one that you referred to about withdrawal of services, that would be a draconian action, is that right? 12:07

A. Well ultimately the arrangements, and again, I would like to give The Inquiry the specific information, but ultimately there are arrangements, from memory within these circulars, where The Trust could take a service from one Trust and give that service to a different Trust, or could take the service from a Trust and give it to a different provider within the third sector. So there are fairly significant arrangements in place within these, but they would be, as you say, I would agree that they would be quite draconian and there would not be a history within Northern Ireland of moving services from one Trust to another or from a Trust to the third sector as a sanction. 12:07 12:08 12:08

126 Q. And indeed it would require an analogous facility in a different Trust area, isn't that right?

A. That's right.

127 Q. So we know that Muckamore Abbey Hospital, for example, is Belfast Trust area and if services were to be withdrawn from there it would depend on services available being available elsewhere, is that right? 12:08

A. Yes, that is correct, but without wanting to speculate there may be other ways that one could do that in terms

of removing responsibility from a facility from one Trust to another Trust, so the hospital remains.

128 Q. But is your evidence that it isn't something that has historically been done often in Northern Ireland?

A. I have no - I am 30 years working in Northern Ireland, I have no knowledge of it being done in my working experience over 30 years. 12:09

129 Q. Okay. Just earlier on you referred to a review of the delegated statutory functions process which took place in 2020 and I said I would come back to that. You refer to that at paragraph 4.23 of your statement. In fact at paragraph 4.27 you refer some of the problems which were considered to exist with the earlier process. This is at page 34 of the statement if it could be brought up please. It is in fact only a couple of lines that I want to refer you to, Mr. Whittle, so I'll read them to you. It says: 12:09 12:09

"The process prior to 2020 was complex and often generated a list of issues without clear actions and time-scales attached to address these. These were frequently rolled over to the following year." 12:10

And you referred to that a little bit in your earlier evidence about the rolling over of targets. Is the result of that, that there were missed opportunities to pick up issues and to remedy them? 12:10

A. I think it's clear from the evidence that I presented there that there was a need to improve because the

arrangements weren't as effective as would have been. However, that said in this evidence module, I have not prepared information on the effectiveness or efficiency of the arrangements in place, rather focusing on the arrangements that were in place.

It is clear to me that arrangements were in place for action planning arrangements prior to 2009. It is also clear to me that they are in need of improvement and reform. The impact of that, in terms of the service to individuals I would hope that the Department would have an opportunity to address in future modules.

130 Q. Yes, and thinking just about potential change that you have referred to, I think that is now underway, is that right? 12:11

A. That's right.

131 Q. You have referred to that at paragraph 4.28 and 4.29 of your statement. Can you tell the Panel a little bit more about that new process?

A. Well, essentially the new process is stronger in terms of the actions that are recorded, the outcomes that are expected, but there is now a rag-rating of red, amber green, I think you saw that on the previous exhibit where Board Officers can meet with the Trusts, have the conversation about how The Trust is progressing. The rating of whether they are compliant green, amber or red is a Health and Social Care Board or SPPG rating. It is not an issue for the Trust self-declared on its assessment of the Trust performance and those actions

plans are made available to the Department of Health, particularly to the Office of Social Services, subsequently through the report at the end of each year. It is tighter than it would have been previously. 12:12

132 Q. Yes, and in terms of the Board's powers or the SPPG's powers, does it have any additional powers under the new process, for example, to impose penalties for failure to comply with action plans?

A. I'd refer, Ms. Kiley, to the circulars that are set out on page 32 of my evidence and I would do a review of those circulars in terms of the powers that are available to the Trust. From recollection it is in OSS circulars of 2022 which set out the arrangements, I would suggest I do a review of those and provide that in information to the Inquiry. 12:12 12:13

133 Q. Yes, those are the circulars you set out at 4.16, are those the ones you are referring to?

A. Yes.

134 Q. Okay. Moving on then to the fourth process which you have set out by which the Board provide quality of care, that's the complaints process. Your statement breaks this down into different timeframe areas, so pre-2009, post-2009. So pre-2009 you deal with, at paragraph 4.33, this is at page 35. You refer there to the introduction of what's described as a "Unified Complaints Procedure" in 1995. You set out the various stages of that. And the first was local resolution which was conducted by The Trusts, and then there was 12:13 12:13

an independent review stage and that is whenever one of the Legacy Boards might have got involved, is that right?

A. That's correct.

135 Q. So under that process the Legacy Boards were actually adjudicators of complaints, is that right? 12:14

A. Yes, at the second stage.

136 Q. At the second stage only. Okay, so if it hadn't been dealt with by The Trust to the satisfaction of the complainant, then it had the potential to move up essentially to the Legacy Boards, is that the way it worked? 12:14

A. Yes, if a complainant remained unhappy under attempts to resolve the complaint under local resolution they could then approach the Health and Social Services Board to request an independent review. The Health and Social Care Board could either reject that request, or it could refer the request back to the Health and Social Services organisation for further local resolution, or it could convene a Panel. 12:15 12:15

137 Q. You then say that things changed in 2009 whenever the single Regional Board was created and a new complaints process was put in place and you set out the new process at paragraph 4.51. You say there that the Board's role changed to one of monitoring and oversight. Are you able to assist the Panel with the reason for that change. So it goes from an adjudicator to one of a monitor, was there a reason for that? 12:15

A. I am unable to set out a rationale for it, but if it

assists The Inquiry I can set out the differences if we're able to turn to page 6217? It sets it out there.

138 Q. Just to navigate us, Mr. Whittle, this is the new complaints procedure that was issued in 2009, isn't that right? 12:16

A. That's right.

139 Q. So what is it that you wanted to draw the Panel's attention to?

A. Can I just have one screen, is that possible? Can we go to the next page please? 12:16

CHAIRPERSON: I think the annex on Standards For Complaints, is that what you're looking for, is at 6220. It may not be.

A. Sorry, my apologies, Chair and the Panel, I had thought that I had made a reference there to the different 12:17 roles that we had in the Monitoring Oversight but that's not the page that has been pulled up, so that's my mistake in preparation, so apologies for that. Can I maybe ask you to repeat the question?

140 Q. Yes, I had asked about whether there was a rationale 12:17 for the change in that role, the change from an adjudicator to a monitor of complaints. You had said that you didn't think you could assist with rationale but you might be able to explain some of the differences. 12:17

It appears though that, you know, in general terms, a monitoring role is a different role for the Board. In that case, so post-2009, is it fair to say that sole

responsibility for the adjudication of complaints was with The Trust?

A. Yes, The Trusts, my understanding of the intention of The Trusts would be closer to the complainant in terms of the resolution of the complaints, so to have an enhanced local resolution. However, the Health and Social Care Board's role in terms of oversight of the complaints monitoring themes or clusters or trends was different from being the arbitrator to actually understanding the totality of the picture with regard to the complaints. 12:18 12:18

141 Q. And under the new system then that came into place after 2009, was there any way in which a complainant could bring a complaint directly to the attention of the Board? 12:18

A. My understanding is not so, that the Board's role was one by way of oversight. However, if a complainant was unhappy with the way in which a complaint had been addressed by a Health and Social Care Trust they would have recourse to the Ombudsman, or in earlier times to the Commissioner for Complaints. 12:19

142 Q. Yes. The Inquiry has heard evidence from some patients, Mr. Whittle, and their relatives which said that they made complaints but, in effect, they didn't feel that they were investigated or responded to and these are complaints in respect of Muckamore Abbey Hospital and complaints to the Trust. 12:19

How then, in this system where the Board had a

monitoring role, how did the Board ensure that patients and relatives were facilitated to make a complaint to the Trust?

A. One of my reflections when considering all of this quality section, is that frequently the Health and Social Care Board is dependant, or has been dependant on the information that's provided to it, whether that's by way of complaint or through reporting to the delegated statutory functions process, or the serious adverse incidents reporting process. 12:20

So the Board's role in terms of having direct access to complainants would be limited to if a complainant approached the Board directly which, from time to time, I understand they have done in the past. But it wouldn't be a routine part of the procedure for them to do so. 12:20

143 Q. If the Board then is dependant on The Trust providing information to it, how does the Board assure itself that the Trust's handling of complaints is robust? 12:20

A. I have set out some detail on page 39 of my statement forward with regard to the structures that are in place to support monitoring oversight and for a complainant. I can talk through that if that's helpful?

144 Q. Yes. Yes. 12:21

A. So, following the formation of the Regional Board, a Regional Complaints Group was established in 2009. It was chaired by a predecessor of me, the Director of Social Care, and the membership would be the Board of

Directors of Complaints but also Patient and Client Council. The Regional Complaints Group reviewed and monitored reports prepared by complaints staff that had been received from respective Trusts.

145 Q. Can I just pause you there, Mr. Whittle, and ask you, are you able to assist the Panel with the type of information that that Complaints Group received from the Trust? So for example, what level of detail might it have heard about a complaint? 12:21

A. Paragraph 4.59 of my statement sets out that the Regional Complaints Subgroup reviewed complaints information received from Trusts and also any complaints received by the PHA. It might assist The Inquiry if I just turn briefly to page 6434 which is the Terms of Reference of that Group. 12:22

146 Q. This is the Terms of Reference of the Regional Complaints Subgroup?

A. Yes, and sorry, can I go back to your question?

147 Q. Yes, so my question was, that really around the type of information that The Trust provided to the Board, so what type of information does it get about the complaints? 12:23

A. Can I just scroll down to the second page please? So you will see there at the start of the page that it received information on the complaints received across the HAC on a quarterly basis. 12:23

148 Q. It refers there to the number of complaints and I suppose that's really what I'm getting at, Mr. Whittle, does the Board or that Group that you have referred us

to, the Regional Complaints Group, does it just receive statistics and numbers from the Trust, or does it receive more substantive information, for example, about the nature of a complaint so that the Board can then go on and analyse trends? 12:24

A. So it would receive both, over the course of a year there would be approximately 6,000 complaints received across the HSC Trusts. Relevant professionals within the Health and Social Care Board and the PHA reviewed the complaints that were received by Programme of Care 12:24 and those professionals would have attended the Regional Complaints Subgroup to give that qualitative analysis of the complaints.

So it's more than just the numbers. They would also 12:24 have staff within the Health and Social Care Board and the Public Health Agency who would have looked at specific complaints and the outcome of those.

149 Q. What did the Board do with that information?

A. So when the Board received monthly reports from each of 12:24 the HSC Trusts, through an agreed monitoring protocol, on receipt of that monitoring report it categorised information into specific areas of complaint.

That information then was subsequently shared with 12:25 designated professionals from either the Health and Social Care Board, or the Public Health Agency who sat as members of the Regional Complaints Subgroup. If those designated professionals deemed further

information was necessary then it was requested from the Health and Social Care Trust.

150 Q. Who are those designated professionals within the Board, what's their role?

A. They would be, in the Board they would be the Social Care Leads, or GP leads, or in the Public Health Agency, they could be nursing leads or Allied Health Professionals Leads, a range of different professionals, again at a middle senior management level within both organisations. 12:26

151 Q. You said there if they considered that more information was necessary it would essentially ask The Trust for that. But if the Board considered that there was a trend in a particular type of complaint that was concerning, what could the Board do about that, if it was concerned that there was - about a particular area, for example, a particular service area? 12:26

A. Ultimately that subgroup could raise it with the senior team of the Health and Social Care Board and the Public Health Agency who, again, in turn could raise the issues with the Department of Health, or those issues could be identified on the complaints report which was prepared on an annual basis and submitted to the Health and Social Care Boards' Board so it could publicise information with regards to concerns with regards to complaints. 12:26 12:27

152 Q. That escalation from the Complaints Group upwards to the full Board, are you aware of that happening in respect of complaints that related to Muckamore Abbey

Hospital?

A. I am not aware of specific complaints being escalated. I am aware that a complaints report was submitted to the Health and Social Care Board on an annual basis. I am also aware that the issue of Muckamore Abbey Hospital was discussed and raised at a number of Board meetings over a number of years, and again, minutes I presume have already been made available to the Inquiry, but can be made available if helpful. 12:27

153 Q. Just further on that report that you have referred to, that is a report, did you say it was published? 12:28

A. The complaints report, yes.

154 Q. Yes, and where is that published?

A. I will clarify the details.

155 Q. What I am really wondering, is it accessible and provided to patients and staff? 12:28

A. Yes. The report would have been a public document in a public Board would have been made available through the Health and Social Care Board's website as a public document. There would be arrangements in place between the Board and the complaints officers in each of the Trusts to ensure that that information is disseminated and cascaded down with regard to themes. 12:28

So I would be confident those arrangements were in place, but because it's not my area of individual responsibility the detail of that, I would prefer to bring back to the Inquiry in terms of the operationalisation of how it actually happened by way 12:28

of a written submission, if helpful, I can't speak to it in detail this morning.

156 Q. CHAIRPERSON: Could I just ask, on the question of trends of complaints that you were being asked about earlier, was there any relationship between those trends being identified and feeding back to the RQIA or inviting the RQIA to take specific action or investigate, do you know? 12:29

A. I don't believe so, Chair.

CHAIRPERSON: So there was no relationship between the Regulator and the Board. 12:29

A. There would be a relationship between the Regulator and the Board, but with regard to complaints I have no recollection of my four years that I have been with the Health and Social Care Board of complaints being discussed with the RQIA, in and terms of my comprehensive document review and preparation for this, it is not an issue which has come to my attention, as to what I have prepared for this Inquiry, so I would believe not. 12:29 12:30

157 Q. Thank you, Mr. Whittle. Chair, that's the end of that topic. I am going to move on to address adverse incidents and serious adverse incidents, but I think this is an appropriate time?

CHAIRPERSON: Yes, sure. I think we have still got quite a way to go. 12:30

MS. KILEY: Yes, we will be probably most of the afternoon but we are on track, we will certainly finish today.

CHAIRPERSON: We don't need to have a short lunch? Okay, one hour then, half-past-one. Is that enough time for you. Thank you very much indeed. We will reconvene at half-past-one. Thank you very much.

12:30

LUNCHEON ADJOURNMENT

THE HEARING RESUMED, AS FOLLOWS, AFTER THE LUNCHEON ADJOURNMENT

13:34

MS. KILEY: Okay, Mr. Whittle, just before the break we were going through the eight processes by which the Health and Social Care Board monitored and improved health and social care structures, and we were on to the fifth, and the fifth process which you set out was 13:34
in respect of legacy adverse incidents and you deal with this at paragraph 4.68, which is page 43 of your statement, and you provide a number of exhibits associated with this process, as you describe it. I don't intend to turn to the exhibits, but I want to ask 13:34
you a little about the process. So you say that this was a process in the Legacy Board where Trusts reported some adverse incidents to the Eastern Health and Social Services Board specifically, and the examples that you have given are for the time period between January '07 13:35
and April 2008, so the Panel will be able to look at those and see the process. But what I wanted to ask you about is whether you can elaborate any more on what the Board's response to that was, whether the Board had

a process for dealing with these things if they were reported?

A. Okay, thank you. What I would say just by way of introduction to the issue of legacy adverse incidents is that the Health and Social Care Board does not collect or routinely monitor adverse incidents, so that would not be part of our operating arrangements since the Regional Health and Social Care Board was established. As part of our searching for preparation for this statement, we had identified that the legacy Eastern Health and Social Services Board did collect adverse incidents and that's why we have reported it here. Now, we have looked to see was there a procedure or a protocol or to govern why the Trusts were submitting to those or what we would do with those and we have not found anything on that, but we know from the adverse incidents that have been recorded on Datex and that which we have shared with you, that there clearly was a process in place for them to be sent to the Legacy Board, but, beyond that, I don't have information in relation to what process was followed. 13:35 13:36 13:36 13:36

158 Q. Okay. And in terms of the process, it appears then that there was a practice, but is it right to say that there was no statutory requirement at that time to report such incidents to the Legacy Board? 13:37

A. Yes, there was, and is currently, no statutory or policy requirement for the Trust to report adverse incidents to the Board. Now, there is a potential issue there, in that if the Health and Social Care

Board or the Legacy Boards are only in receipt of the monitoring arrangements for serious adverse incidents, it's very difficult to understand the impact of that in the context of you don't know how many incidents you are having or the nature of other incidents, so there is potential for further oversight were adverse incidents collected, but that's not the policy or the legislative basis. However, I thought it would be remiss of me to produce the statement and not reference the fact that the Eastern Board did collect them. 13:37 13:38

159 Q. Yes. And you've touched there on the next topic or process that I want to come to, and that's serious adverse incidents. You have listed that as your sixth process by which the Board monitored and improved health and social care. You deal with this at paragraphs 4.7 to 4.73 of your statement. Again, you break this process down into pre-2009 and post-2009 because there were some changes in the process. So I just want to start with pre-2009 first, and you summarise this in the first three paragraphs: 4.7, 4.71, 4.72. In summary, Mr. Whittle, is it right to say then that the process pre-2006 was that SAIs were reported to the Department and then the change came in March 2006 that required SAIs to be reported also to the Board alongside that reporting? 13:38 13:38 13:39

A. Yes, that's right.

160 Q. And the Inquiry has heard from Mr. McGuicken, as you know about, from the Department of Health, in respect of reporting SAIs to the Department, but March 2006 was

the first point in time that SAIs were required to be reported to the Board, is that right?

A. Yes.

161 Q. So that's the Legacy Boards in 2006, isn't that right?

A. Sorry, can I just -- could I ask you to repeat that last statement again, please? 13:39

162 Q. Was March 2006 the first time at which the SAIs were required to be reported to the Board as opposed to the Department?

A. I'm minded by paragraph 4.70, which reads: 13:39

"Department of Health Circular 06/04 introduced interim guidance on reporting and follow-up of SAIs - Exhibit 91."

163 Q. Yes.

A. "Its purpose was to provide guidance for Health and Personal Social Services organisations and Special Agencies on the reporting and management of SAIs and near misses." 13:40

That's a 2004 circular.

164 Q. Yes. And the next paragraph refers to an update on the safety issues which came in 2005. And then at paragraph 4.72, you refer to a further update in 2006 and you say that "That circular drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified organisations of the changes in the ways SAIs should be reported in the future and provided a revised -- a report pro forma." 13:40 13:40

And then you go on to say: "It also advised that

Trusts and practices should note that all SAIs should be reported to their HSS Board as a matter of course."

A. Yes.

165 Q. So it appeared then that that requirement to report to the Board arises from the 2006 Circular which you refer to, is that right? 13:41

A. Yes, that's correct. However, to be comprehensive, I would like to go back and review Circular 06/04 to clarify whether there is any requirement in that for the Legacy Boards to be notified in 2004. 13:41

166 Q. Yes.

A. It's just when you said 2006, I just want to be clear that it wasn't, in fact, 2004, but I am very happy to take that off the table and come back to the Inquiry with the specifics in relation to that. What I can say 13:41 is that each of those three circulars, one strengthen the other in terms of development of reporting of SAIs and the rationale behind the introduction of the 2004 circular related to the death of a child and the need to inform the Department of the circumstances of 13:42 serious incidents?

167 Q. Okay. And we can clarify the position between 2004 and 2006, but we know from 2006 that they certainly had to be reported to the Board, but that reporting was alongside a report to the Department, so are you able 13:42 to tell the Panel any more about what the Board did, if anything, when it received the SAI reports; did it receive them at that stage for information only or was the Board required to take action?

A. The Board would be required to take action insomuch as it would oversee that a review was undertaken. The review would be undertaken by the Trust, not by the Board, but the Board would have particular responsibilities with regard to ensuring that the appropriate review was undertaken by a Trust, and also, to report any regional learning that comes out of a review that any one Trust might undertake.

168 Q. And are you able to say anything more about the interaction between the Board and the Department, so thinking about that pre-2009 period, so before the regional Board was established, are you able to say anything more about the interaction between the Health and Social Care Board and the Department of Health whenever SAIs were being reported to both bodies, essentially? 13:42 13:43 13:43

A. Not beyond that which is included in my statements.

169 Q. Okay. Well, you do go on then to explain some changes that took place post-2009, and at paragraph 4.74, in particular, you refer to a change in the process which was brought about in May 2010 and that required SAIs to be reported to the Regional Board in the first instance rather than the Department of Health, and you provided information on that, including the relevant circulars, but, as you know, the Inquiry has already heard from Mark McGuckin on behalf of the Department about that, so I am not going to ask you to explain that process again; the Department has already addressed the Inquiry on that, but there is just one issue that I wanted to 13:43 13:44

ask you about. It appears that the new process for notification to the Board involved a designated review officer, and that is the person who -- in the Board who was responsible for the review of investigation reports completed by the Trusts. Are you able to assist the Panel any more about the role, who carried out that role within the Board, so what their level of seniority would be, what their background was? 13:44

A. Yeah, a designated review officer would be most frequently a professionally-qualified member of the Health and Social Care Board, or indeed the Public Health Agency, so it would be predominantly a social worker within the Health and Social Care Board. Within the Public Health Agency, it would be a nurse, an allied health profession or a doctor. In terms of the seniority, it would be very similar to the evidence that I gave earlier in terms of middle to senior management grades within the Health and Social Care Board. 13:45 13:45

170 Q. And would those persons receive additional training specifically directed to the DRO role? 13:45

A. I haven't got the evidence before me with regard to the training that is received. I would expect that to be the case, certainly in terms of induction and instruction from line managers. Whether or not there was specific training to DROs, I am afraid I don't know this afternoon, but again, I am happy to make inquiries both within the Heath and Social Care Board and/or the PHA to clarify that and give that information 13:45

subsequently to the Inquiry.

171 Q. Okay. I want to move on to the significant update in procedure which you describe in 2013, and you explain this at paragraph 4.76.3 of your statement, this is at page 45, and this paragraph encapsulates the change that took place in 2013, so I'll read that and ask you some questions about it. You say: "The single investigation process for SAIs was updated in 2013 and introduced three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning. Level 1 reviews required a Significant Event Audit (SEA) which could be undertaken for less complex SAI reviews. Level 2 and Level 3 reviews continued to be reviewed using Root Cause Analysis (RCA) methodology. Timescales for conducting investigations were revised in line with the level of investigation to be undertaken." 13:46 13:46 13:47 13:47

Are you able to tell the Panel any more about why that change was introduced in 2013?

A. The change was introduced to reflect the complexity of the serious adverse incidents that could come before the Health and Social Care Board or the Public Health Agency, so, by way of example, a serious event audit would be for more non-complex serious adverse incidents, one where the learning could be quickly undertaken by a Health and Social Services -- sorry, a Health and Social Care Trust, without extensive oversight by the Health and Social Care Board, whereas 13:47

a Level 2 would require a root cause analysis and would require oversight by both the Health and Social Care Board and the Public Health Agency. The Level 3 serious adverse incident gave an extra level of independence to the review, to the Review Team being independent, but it still utilised a root cause analysis arrangement. So, simply put, Level 1: less complex, quick learning, organised by the Trust; Level 2: a more detailed root cause analysis organised by the Trust but with oversight by the Board and the PHA; and Level 3: extra independence of the Review Team with the Trust. 13:48 13:48

172 Q. Yes. And I wanted just to hone in on each of those levels briefly. So Level 1 is the lowest level of entry of an SAI. Who decides whether something falls into the category of a Level 1 SEA; is that the Trust or the Board? 13:49

A. If you just bear with me, I am going to turn us, if I may, to page 47 of my evidence. I was hoping that if I turned to page 47 which is sets out on paragraph 4.79 that it would set out who makes that determination. You will see there that: 13:49

"The SEA Review should be conducted at the appropriate level and proportionate to the complexity of the Review, organisations may use a regional risk maintenance matrix to determine the seriousness and subsequently the level of each to be undertaken." 13:50

And it sets out the three levels. My understanding, and I will need check this for The Inquiry, my understanding is that the designated responsible officer has a particular responsibility with regard to ensuring that the appropriate level of view is undertaken, but I would like to clarify that, that's my understanding, but it is not on the point of the evidence I thought I was going to turn to. I just want a belt and braces to check on that.

13:50

CHAIRPERSON: I see you touch on this at 4.83 actually.

13:50

MS. KILEY: It's at page 49.

A. Yes. Sorry, Chair, thank you very much indeed. I think to give further assistance I might suggest under 4.83, which is on page 49 of the statement, I will actually turn us to page 6627 which is the actual procedure and I think that may well assist us.

13:51

173 Q. Yes, this is the procedures document that was introduced after the change in 2013?

A. Yes.

174 Q. And this is the role of the Designated Review Officer, is this what you wanted to draw our attention to?

13:51

A. Yes, if I might just take a moment to read through some salient points. So a DRO is the Senior Professional Officer of the Board of the PHA, has a key role in the implementation of the process, liaising with the reporting organisation on an immediate action to be taken following a serious adverse incident and secondly, where the Designated Review Officer believes that the SAI is not being undertaken at the appropriate

13:51

level.

So the DRO in those circumstances would be able to identify if this was the correct Level 1, 2 or 3 and then, further, the DRO has a responsibility with regards to agreeing or approving the Terms of Reference for Level 2 Reviews where the Health and Social Care Board and PHA would have oversight or for independent reviews under Level 3. Hopefully that addresses your questions. 13:52

175 Q. Yes, and so is it right to say then that in terms of who decides what level it enters the process at, in the first instance it's The Trust, is that right, if it was to consider that it was appropriate to enter the process at Level 1 at SEA level, but then there would be a review by the DRO to consider whether that is appropriate? 13:53

A. Yes, the check and balance rests with the DRO, so they have the final say to be assured that it is the appropriate level, but the original suggestion or identification would come from The Trust. 13:53

176 Q. And an SEA, even if it does enter Level 1 can be moved up to Level 2 or indeed Level 3, so who makes that decision?

A. The DRO. 13:53

177 Q. Okay, so is the SEA Level 1 really a sort of filter then for the less serious, relatively, of those incidents?

A. Well less so in my view as a filter, more so to make

sure that Health and Social Care Trusts take every opportunity to achieve early learning. As The Inquiry will be aware, to undertake a serious adverse incident using a root cause analysis does take some considerable time. Sometimes learning can be identified quickly and put on the ground quicker by doing an SEA, I think that was the intention behind the introduction of the levels.

178 Q. If an SAI remained at that level, so didn't progress up to Level 2 or Level 3 and essentially ended at Level 1 and the DRO considered that that was appropriate, essentially that ends with just a Trust level investigation, is that right? 13:54

A. Yes.

179 Q. So it doesn't move on to the detailed root cause analysis that you have referred to? 13:54

A. Yes.

180 Q. Okay. So thinking then about Level 2. This is actually addressed in the document that we are looking at which is the procedure. It may be useful to look at page 6556 please because Level 2 is addressed here. So there's reference to the root cause analysis that you have just referred to. Can you tell the Panel a bit more about that process. You have referred to it being a lengthy process. Can you tell the Panel a bit more about what it involves? 13:55 13:55

A. Essentially a Level 2 would involve the Health and Social Care Trust considering the detail of the incident that had happened, any events that have led up

to the incident to liaise with members of the multidisciplinary team, the patient or client, and their family, to go through a process of understanding the reasons for the incident and coming up with identifying any contributory or causal factors and then making a recommendations with regard to the learning against those.

181 Q. And is that the case if recommendations are made at that level, does that mean that the SAI has ended at that level rather than moved up to Level 3? 13:56

A. The Review would be concluded at Level 2 which would be root cause analysis. It would then come back to the Designated Review Officer who would have to be assured of the thoroughness, the appropriateness of the review that was undertaken, the recommendations that were made, to have the appropriate recommendations being made on the basis of the evidence that is being provided and, finally, whether or not there is any regional learning beyond that which the individual Trust will take forward, is the learning for the broader HSC across Northern Ireland. 13:56 13:57

182 Q. What would cause something to move up to Level 3 then?

A. Level 3 would be a determination taken earlier in the process, at the point of the referral, about whether or not an incident required a level of independence of a Review Team. So that would tend to be those serious incidents which are the most serious or ones which potentially there would be a level of a need to assure the public and the broader HSC of the independence of 13:57

the review, that you would have fresh eyes, independent eyes on that review.

183 Q. I think we can see that if we could scroll further down this page to 6557. Level 3 is the Independent Investigation Level. And you can see the three bullet points: 13:58

"Level 3 investigations will be considered that are particularly complex, involving multiple organisations, have a degree of technical complexity that require independent expert advice, are very high profile and attracting a high level of both public and media attention." 13:58

And there is further information there. Did you say whether it is a Level 3 is something that would be decided earlier on in the process? 13:58

A. Yes.

184 Q. Who decides that?

A. The DRO. 13:58

185 Q. The DRO?

A. The Trust makes, I suppose in layman's terms The Trust makes a call, that comes through to the Board, the Board then allocates a Designated Review Officer either from the Board or the Public Health Agency, they put eyes on it, they then determine if The Trust's review level is appropriate or not and then there follows a Level 1, a Level 2 or a Level 3 Review. 13:58

186 Q. Okay. And you then explain that there was in fact a

further update to that procedure in November 2016. You refer to this at paragraph 4.77 of your statement. You summarise the main changes there. This is at page 45 of the statement please.

13:59

You have provided the actual procedure within your exhibits, but at paragraph 4.77 you explain that there was a further updated procedure issued in November 2016 and you then summarise the main changes. Now, they are there for the Panel to see, I'm not going to read them all. But I wanted to pick-up on one particular issue with you, at paragraph 4.77.1, you say:

13:59

"Quality assurance of Level 1 SEA review reports. The HSCB would not routinely receive SEA reports unless specifically requested by the Designated Review Officer, instead HSCB would receive a learning summary report which only detailed the learning and recommendations following review, as opposed to the full detail of what happened. This change in process assigned reporting organisations the responsibility for quality assuring Level 1 SEA reviews. This would entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to the submission of a learning summary report to the HSCB."

14:00

14:00

14:00

So, is it right to say then that prior to this change in 2016 The Trust itself could just review at SEA level

and decide to close it at that level, is that right?

A. I actually believe it's the other way round, that the SEA - all SEAs were submitted to the Health and Social Care Board prior to this point, but I'll clarify that to confirm my understanding is correct. 14:01

187 Q. Okay. My next question was about, you've talked about submission to the Health and Social Care Board, this applies to both SEAs and the different levels of the SAI process. How did the Board monitor patterns that were reported in respect of SAIs? 14:01

A. I am going to ask, with The Inquiry's permission, that I give written information in relation to that. I believe that there was a quality report that was prepared and submitted to the Health and Social Care Board, however, I haven't prepared the detail of that 14:02 for my evidence. So I would like to clarify the circumstances in relation to that and provide a written response if that's acceptable.

188 Q. Yes. So, are you saying that you think there is a procedure around that monitoring? 14:02

A. From personal memory of being, for the one year that I was on the Health and Social Care Board's Board, a quality report was submitted to the Health and Social Care Board and I believe that that covered SAIs, but however, as I haven't prepared the detail behind that I 14:02 would like to check that and confirm that with you subsequently.

189 Q. Okay. Well, we have discussed the Board's role in the SAI process generally. Are you able to assist the

Panel with whether the Board took any action itself to ensure that staff members in a service area were aware of the requirements of reporting to the Board?

A. I'm not aware of any particular role that the Board had had in that regard, I would anticipate that would be a role for the Health and Social Care Trusts to ensure that their staff were fully aware of the procedures and the arrangements that they would follow. 14:03

CHAIRPERSON: Sorry, Ms. Kiley, when you say a "service area" meaning what? 14:03

MS. KILEY: I'm thinking particularly in respect of Learning Disability and particularly thinking about staff who were working at Muckamore Abbey Hospital. How was the Board assured that people working there knew their obligations in respect of identifying adverse incidents and then allowing those to move up the chain of reporting if there were serious adverse incidents. 14:04

A. My understanding with regard to that is that it would be a matter for the health and Social Care Trust to ensure that its staff were aware of the regional policies, procedures and how to expedite them. I don't believe that the Health and Social Care Board would have had a particular role in assurance of individual staff training or awareness with regard to procedures. 14:04

190 Q. Okay. Is there any way then that the Board was able to satisfy itself that those things that ought to have been reported as SAIs were in fact being reported?

A. The Health and Social Care Board would have had limited

ability to satisfy itself in that regard. Essentially serious adverse incidents are called by the Health and Social Care Trust, so the Health and Social Care Board would only become aware of them if they were referred as a serious adverse incident. There may be, potentially, other processes which are set out in this chapter which could identify an incident which would cause the Board to check, so, by way of example, if the Board was aware of a particular complaint that it thought had hit the threshold for a serious adverse incident, it could address that with the Trust if it hadn't received a referral. Likewise, if the Health and Social Care Board received a notification for an early alert and it hadn't, it would be able to check that against whether a serious adverse incident had occurred. So there would be some checks and balances with regard to other processes, but in terms of the absolute position, the Health and Social Care Trust refers the SAI to the Board and the Board only knows what it is told in that space. 14:05 14:05 14:06 14:06

191 Q. Yes. And you refer there in your answer to the early alert process, amongst other things, and I want to come on now to deal with the early alert process; it's the seventh process that you had referred to. You refer to this at paragraph 4.89 of your statement. The early alert process is a requirement to notify the Department of Health, isn't that right? 14:06

A. That's correct.

192 Q. And the Panel has already heard evidence about the

early alert process from Mark McGuckin on behalf of the Department of Health, so I won't ask you to explain the process itself, but are you able to tell the Panel what the Board's role in the EA process is?

A. The Board has a very limited role in the early alert process, as we would know from the earlier evidence submitted to the Inquiry. Essentially, the role of the early alert is to make sure that the Minister and the Department are aware of significant issues that emerge in Health and Social Care Trusts, so the rationale for that is notification, maybe there would be adverse publicity or maybe there is a need to know in terms of other issues. It is not a learning process, it is a notification, whereas the serious adverse incident is the mechanism by way in which the HSC system learns with regard to incidents that have happened. So the role of the Health and Social Care Board with regard to early alerts is (a) to receive them and (b) to check whether or not they hit the threshold for serious adverse incidents where there may be regional learning and, if so, to ensure that that regional learning takes place, which would be through the serious adverse incident process that we have just gone through. 14:07 14:07 14:07 14:08 14:08

193 Q. Okay. And the final process that you refer to in your statement is a safety and quality alert process, SQA. You deal with this at paragraph 4.93 onwards. Can you explain briefly to the Panel what a safety and quality alert is?

A. I think probably the easiest way to do that, if I could

ask if you could maybe pull up page 6,805.

194 Q. Yes, this is the --

A. This is the regional procedure between the Health and Social Care Board and the Public Health Agency and it sets out what a safety and quality alert is. 14:09

195 Q. Yes. And the policy, I think, is 2012, is that right?

A. That's correct. So, if you see there on paragraph 2: "What are safety and quality alerts? Safety and quality alerts are the regional process which the Health and Social Care Board and the Public Health 14:09 Agency oversee the identification, co-ordination, dissemination and implementation of learning. Safety and quality alerts are subdivided into a number of categories detailed below. Firstly...".

14:09

Sorry, that jumped and I have lost my page.

"Department of Health safety and quality standards guidance and letters, circulars and patient safety alerts" is the first bullet point there. And then it 14:09 goes on through a number of other bullet points: "Learning letters, RQIA reports and independent reviews, NCEPOD - National Confidential Enquiry into Patient Outcomes and Death Reports, and learning notifications." 14:10

So that would be the suite of safety and quality alerts.

196 Q. And so can a safety and quality alert potentially be issued then as a consequence of the Board's findings

having dealt with an SAI; is there an interrelationship between the two?

A. With regard to learning letters, it could fall out of a serious adverse incident, resulting in the learning letter, which would be issued through this arrangement. 14:10

197 Q. Okay. Are you able to say whether any learning letters were issued to the Belfast Trust in respect of Muckamore Abbey Hospital arising from any SAIs?

A. I don't have that information before me this afternoon, but I can conduct a further thorough search and provide confirmation one way or the other to the Inquiry. 14:11

198 Q. The process for issuing and disseminating the various types of SQAs is described in the policy that you have referred to, and the policy refers to a Safety and Quality Alert Team, which is said to be a joint PHA and Board team. Are you able to tell the Panel any more about its makeup? It's referred to at page 6,814, if that's of assistance, if we could turn to that. 14:11

A. Sorry, which paragraph are we referring to?

199 Q. Do you see paragraph 5.3.1: "Criteria for identifying regional action and assurance levels, the PHA HSCB SQA Team"? 14:12

A. Sorry, the Public Health Agency and the Health and Social Care Board employ a number of staff who would work collectively on these issues, so there would be a head of governance and there would be members of that team and, likewise from the Public Health Agency, there would be a number of staff that would work together, and I believe they are the Safety and Quality Alert 14:12

Team. It's effectively the governance staff from within both the Health and Social Care Board and the Public Health Agency.

200 Q. Yes. And it says there that they "will determine the detail of the method of assuring implementation of an alert." What does that mean? Do they have a role in ensuring that the alert is disseminated and adhered to and, if so, how do they do that? 14:12

A. By -- I believe that refers to they'll have a role to determine whether it is a learning letter or a newsletter or some of the other vehicles. Some of these are very straightforward. An RQIA review is an RQIA review and it'll be sent as an RQIA review or an NC [inaudible] point review goes out as that. There are others would have more discretion for a team in terms of how they get the learning out to the team or to the HSC. 14:13 14:13

201 Q. And in terms of the Board's role, once it issues a safety quality alert, whether that be a learning letter or one of the other methods, does it end there or does the Board have a monitoring process to ensure that the issue which it identified has been remedied? 14:13

A. There are some arrangements which are set out with regard to assurance levels.

202 Q. Is this at paragraph 4.96 of your statement? This is at page 53, I think? 14:14

A. Yes. So, in May 2021, so relatively recently, the Health and Social Care Board introduced a process, which continues to be used to date, whereby, upon

issue, safety and quality alerts were categorised by the degree of assurance required by both the Board and the Public Health Agency. Three categories were introduced: first line assurance - no response to actions is required to the Board or the PHA; the second line assurance - a response is required to the Board and PHA within four weeks confirming that actions have been added to the organisation's safety and quality assurance work plan; and lastly, the third line assurance - that the response to the Board and the PHA is required, within 12 weeks, confirming actions specified within the safety and quality alert have been completed. 14:14 14:15

203 Q. And that's introduced in May 2021. Was there a similar assurance process before that? 14:15

A. I do not believe that there was.

204 Q. I want to move on to the next topic, which is the final one in Module 2, Topic 2I, "Outline of Provision for Community-Based Services", and you can see you deal with that in the section directly below the one we have just been looking at, paragraph 5.1 of your statement. I just want to pick up on an issue that you raise at paragraph 5.11, so if we could turn up page 55, please, and you say here, Mr. Whittle: 14:15

"The majority of those living with learning disabilities were supported at home by families. Where an individual with a learning disability became unwell due to a mental health condition or their behaviour presentation became difficult to manage in the 14:16

community, assessment and treatment could be provided by a psychiatrist in the community or as an in-patient receiving hospital-based assessment and treatment. Hospitals were also used to provide respite care as a means of supporting carers."

And I want to pick up on your reference there to the assessment and treatment that could be provided by psychiatrists in the community. Are you aware of whether there was access to other professionals such as psychologists or behavioural therapists in a community setting?

A. So, since I've referenced earlier in my evidence that I have either heard or read the transcripts of previous witnesses, which has given me further opportunity to review what I had written in my evidence, so, since preparing this statement, I have read the transcript of Roy McConkey, who had referred in his evidence to a 1990s Eastern Board document on a model for community-based services. He referred to it in his evidence as a precursor to Bamford, but noted that he did not have a copy of the report. So, upon hearing that and mindful that I have given written evidence with regard to community-based services, I arranged for a comprehensive search and found a document of 1996 which I wouldn't have found in earlier searches because it was prior to the terms of reference that the Inquiry had set, and that document is titled "Eastern Health and Social Services Board - A model of community-based

services for people with learning disabilities, August 1996". I will, of course, make this available to the Inquiry. It is a comprehensive document that sets out a vision for 2002 and beyond. It also lists what was commissioned in 1996. It sets out the principles that then underpinned service delivery and it set out a commissioning framework which specified social care arrangements, accommodation arrangements, respite arrangements, day activity, community learning disability teams, which may go some way to answer your question about the nature of those teams, rehabilitation, in-patient care and severe behavioural disturbance. It goes on to set the financial context and gives an implementation plan. So that report I will make available, and I think that will be of great assistance to the Inquiry in terms of the community-based provision, which wouldn't have been available at the point that I made -- sorry, I wasn't cited on it -- at the point that I wrote this statement. That said, there is a congruence between what I have written here and what I have subsequently read in this report, but I am mindful the Inquiry hasn't seen it.

14:18 14:19 14:19 14:20 14:20

205 Q. Yes. And you refer there to the community learning disability teams. Are you saying that they would have included the type of professionals that I refer to - psychologists, behavioural support therapists?

A. I haven't got the document in front of me today.

206 Q. If you can't take it any further, then that's okay.

A. I can't take it any further than I have.
PROFESSOR MURPHY: Sorry, could I just clarify, was that an aspirational document, though; in other words, this is what we would like to see?
A. It is referred to as a commissioning framework, so it would be setting out the arrangements that the Eastern Health and Social Services Board at the time intended to commission. I'm mindful that, like the Inquiry, I've heard what Professor McConkey had said and he had referred in his evidence, I believe, to it being a precursor and informed the thinking which had then ultimately led to the Bamford arrangements. Beyond that, with the passage of time, and I don't have personal knowledge of it other than the document, but, as I said earlier, I do think it would be helpful to the Inquiry. 14:20 14:21 14:21
CHAIRPERSON: Thank you.
207 Q. MS. KILEY: But beyond the policy aspirations, are you able to say whether those sorts of services were actually commissioned by the Board? 14:21
A. That's a very broad-ranging question. If we look back over the passage of time from 1996 to now, the Legacy Boards and the Health and Social Care Boards regionally have commissioned a range of accommodation services, respite services, daytime activities, all of these issues here have been commissioned over a period of time and there is a significant difference between what was commissioned in the mid-'90s due to what's commissioned currently today. 14:22

208 Q. Thank you, Mr. Whittle. I want to move on then to Module 3, and these are the Policy and Procedure Modules. Dealing firstly with Module 3A, you address that; this is the policy for delivering health and social care to learning disability patients between 1999 and 2021. You address this at paragraph 6.1 to 6.17 of your statement. And at paragraph 6.2, you make an important contextual statement and I just want to just set that out. You say: 14:22

"It is important to note that across the period of the Inquiry's terms of reference, neither the HSSB nor the HSCB had a role in creating policies. The role of these organisations was in the practical planning and delivery of policy intent, not the development of policy. During this period, all policy decisions regarding the delivery of HSC services were made by the Department of Health?". 14:23

Now, you then go on to set out the relevant policy drivers and the applicable policies, but are you really saying there that it is the Department that set the policy and the Board essentially attempted to deliver it with the services it commissioned? 14:23

A. Yes. 14:23

209 Q. And did the Board have any input into the creation of policy, given that it was the one tasked with that delivery?

A. My experience over a number of years of working in

Northern Ireland is that the Department of Health, in its various forms, has worked collectively and collaboratively with Boards and Trusts. That's a personal experience, having worked here over a number of decades. The detail of how they had contributed to these policies, I wouldn't have personal insight, other than that general comment.

210 Q. Okay. The Inquiry has heard again from the Department on the particular policies, so I won't ask you to go through those, and I want to move then to the next module, 3B, "Nursing Care Delivery Model". You deal with this at paragraph 7.1 to 7.5. And at paragraph 7.1 - this is at page 60 - you say: 14:24 14:24

"The nursing care delivery model was essentially an operational matter for the provider, HSS Trust and HSC Trust - that's the North and West Belfast HSS Trust and subsequently the Belfast HSC Trust. The role of the HSSBs and the HSCB was with regard to service commissioning and oversight of quality." 14:25 14:25

And that has been set out in section 4.
So whilst you say there that the nursing care delivery model was a matter for the Trust, the Inquiry has heard about the Department's role in setting requirements, for example, for the nursing workforce, so, for example, by setting the skills of nurses in particular fields and required numbers. Does the Board have any role in that process? 14:25

A. The Health and Social Care Board would not have had a role with regard to setting the numbers or volumes of nurses. However, again, having reflected on the evidence that's gone before me, I am mindful that the Department had established normative nursing numbers under the Delivering Care document and that had influenced the Health and Social Care Board's commissioning plan. So I had given evidence earlier on to say that Health and Social Care Board would produce a commissioning plan that would set out what would happen and what Trusts would do. The plan would be approved also by the Public Health Agency. Investment templates, and which we would refer to as IPT, investment planning templates would be done in partnership with the Health and Social Care Board and PHA staff and those would set out the establishment of staffing to inform any investment. So, within that, there would be the requirement to deliver the investment in line with the normative nursing standards that would be in place. So, the nursing model, whilst the Health and Social Care Board would not set the numbers of nursing staff that would be available, we would take into account, as we commissioned our services, the policy intent with regard to nursing numbers, and reflect that in our investments as we take that work forward. 14:26 14:26 14:27 14:27 14:27

211 Q. And is it something which is specifically reflected in the contracts which the Board entered into with the Trusts? So, for example, would they ever make

reference to the number or the skills of workforce required to meet or deliver the service which is commissioned?

A. The normative nursing model was put in place under a number of phases and would have started initially with acute and surgical and moved on to elective care and others outside of mental health and/or learning disability, but those would be the issues that we would take into account when we commission our services. 14:28

212 Q. Yes, but thinking particularly of the contracts that the Board enters into with the Trust, would one -- if one was to look at those, would we see, for example, reference to the number of staff that the Board considered were required to deliver the service that it was commissioning? 14:28 14:29

A. I suppose, put simply, as the Health and Social Care Board would make investments, it would need to make sure that that investment was able to deliver what was required, so, in order to do that, you would need to build up your investment, taking into account the number of nurses, allied health professionals, social workers, doctors, whatever it was, that was required to deliver the service, which would result in a quantum of money which would be then established within the investment planning templates. In doing that process of investment, the Health and Social Care Board would work with the Public Health Agency to ensure that we had the appropriate numbers of nursing or other staff available to deliver the planned intent. But that is 14:29 14:29

slightly different from saying that we have a nursing delivery model. There is a policy for how many nurses you need for safe staffing. We have an investment where we try and ensure that we build that up from the ground up in terms of what we wish to buy and then that's reflected in our investment planning templates.

213 Q. Yes.

DR. MAXWELL: Can I ask what the relationship to the Department of Health's Chief Nursing Officer and Directorate is, because the Chief Nursing Officer commissions work from NIPEC, so, for example, they produced a delegation framework which explains what work can be delegated to unregistered staff, nursing assistants, the Chief Nursing Officer has done quite a lot of work about a nursing delivery model; how does that relate to the HSCB or indeed the SPGG?

A. So both the Health and Social Care Board and, currently, the Department of Health Strategic Planning Performance Group do not, and did not, employ a director of nursing within our Board structure, and that is where we would rely heavily on the Public Health Agency's director of nursing, where you have the double lock in terms of commissioning plans between the Board and the PHA and advice then from the director of nursing and his or her team with regard to how we build up investment planning templates. So it would be how we -- the way in which we would take this work forward with regard to nursing models and investments, would be by working through a multidisciplinary planning team,

so we would have, by way of example, learning disability services, there would be a planning team which would have a public health doctor, a public health nurse, a social worker, a primary care lead, and they would work together to develop the plans and to sign off business planning templates at a lower level than the sign-off of the commissioning plan direction.

DR. MAXWELL: So I understand there is a relationship with the Public Health Agency and I understand the director of nursing, Public Health Agency attended the HSCB, but I am asking what the relationship with the Chief Nursing Officer who sits on the Department of health is?

A. No, my apologies, there would -- I would not have a reporting line, or the other directors within SPPG, to the Chief Nursing Officer. I would report up using my deputy secretary currently within the Health and Social Care Board. As the Director of Children's and Social Care, I was an executive director of social work, and my professional reporting line would have been to the Chief Social Services Officer, whereas the Public Health Agency's director of nursing line would have been to the chief nurse and I would have worked closely with the director of nursing with regard to how we planned together professionally. I would have gone through a social work line. My PHA director colleague would have gone through a CNO line, but on a day-to-day basis, the expectation was that we would work hand in glove -- but that report line would be nurse to nurse

and social worker to social worker.

DR. MAXWELL: Okay. So in terms of the best practice advice coming out from NIPEC and the Chief Nursing Officer's advisory group, CNMAC - I can't remember what it stands for - HSCB and SPPG wouldn't be monitoring whether Trusts were adhering to those best practice documents? 14:33

A. No.

DR. MAXWELL: Okay. Thank you.

214 Q. MS. KILEY: If it wasn't monitoring, what would happen if the Board became aware of an issue; for example, the Inquiry has heard about issues of -- workforce issues with Muckamore Abbey Hospital, high reliance on agency staff and a lack of learning-disability-specific trained nurses, so if that was an issue in a service which the Board commissioned, how would the Board know about it? 14:33 14:34

A. The vehicles by way in which the Board would know about it are the ones which were set out in the earlier sections, so that would be our -- whether they came to us through -- on the side of complaints or serious adverse incidents or early alerts or delegated statutory functions or performance management arrangements, that's how we would become aware of information. That said, historically, so sadly in terms of my experience within the Health and Social Care Board, there has been a close working relationship between the directors of the Board and the directors of the Trusts and there would be a flow of communication 14:34 14:34

between them, so it could be that information would come to the Board directly from director to director, Trust to Board, in addition to those arrangements that are set out.

215 Q. And if it did come to the Board's attention, then what would the Board be able to do about it? Are we back to the performance management procedures which we discussed earlier, the action plan, et cetera, or is there anything else over and above that that the Board would have been able to do? 14:35

A. I would refer The Inquiry to the earlier evidence that I have given with regard to the steps and the arrangements that we have in place. I am not aware of anything in addition to that.

216 Q. I want to move on then to Module 3C and this is policies regarding restraint and seclusion. You deal with this at 8.1 of your statement, page 61? 14:35

CHAIRPERSON: Shall we just do the next section and take a break?

217 Q. MS. KILEY: Yes, this is a short section, Chair. You deal with this at paragraph 8.1 to 8.16. You provided detailed information on the policies, but it is again the case that regional policy on restraint and seclusion is developed by the Department and local policies are developed by The Trust, isn't that right? 14:36

A. Yes, that's correct.

218 Q. And does the Board, the Regional Board have any role in the development of either of those tiers of policy?

A. Sorry could you repeat that?

219 Q. So thinking of the policies that are developed by both the Department, by The Trusts, does the Health and Social Care Board have any input into that policy development?

A. Again, I would refer back to the general point I made earlier that my experience of the Department of Health and its predecessor organisations is one where it has worked collaboratively with Boards and HSC Trusts in terms of developing policy. So I would anticipate and expect that there would be discussions and developments, and certainly as policies developed it would be very frequent for Health and Social Care Board and Trusts to be represented on Groups which are organised by the Department to formulate policy, but ultimately the authority or the accountability for the development policy will sit with the policy side and Mark McGuicken has given his evidence in that regard. 14:36 14:37 14:37

220 Q. Did the Health and Social Care Board monitor The Trust's compliance with restraint and seclusion policies? 14:37

A. I'm not aware. I do not believe that there is any specific monitoring of compliance other than the measures that I have already set out. If an issue with regard to restraint were to emerge as consequence of a complaint, or a series adverse incident, or an early alert, or the delegated statutory function arrangements we would be aware of it, but over and above those pillars there is no specific monitoring with regard to restraint or seclusion. 14:38

221 Q. Okay. So those processes, the eight processes that we went through, are the ways in which the Board would know about it and the performance management processes which you have already explained are the vehicle by which the Board could do something about it? 14:38

A. Yes.

222 Q. You have referred in this section to a report prepared by the EHSSB in 1999. Now, it predates The Inquiry's timeline, this was a report that was produced in June 1999. This is at paragraph 8.4 of your statement and 14:39 this is where the Legacy Board investigated the use of seclusion in Fintona Ward. You have provided that report in your exhibits it and makes a number of conclusions and recommendations, I am not going to go through it in detail, but the Panel have it. But you 14:39 summarise the findings of the report at 8.6 of your statement and you say:

"The report in its conclusions and recommendations identified no evidence of abuse in the use of seclusion 14:39 in Fintona but did make a number of recommendations. It noted the need to reduce seclusion overall and recommended improvement in the built environment by renovation work, improved staffing ratios and the keeping of records of both voluntary and involuntary 14:40 seclusion."

So that's a report by the Board on the use of seclusion at Muckamore Abbey just at the cusp of the timeframe

which this Inquiry is looking at. Are you aware of any follow-up from the Eastern Health and Social Services Board after that report with a view to implementing the recommendations?

A. No, I am only aware of the information that I put before the Inquiry in terms of the reports available and the recommendations, but beyond that I don't have any further information. 14:40

223 Q. Okay. I think now would be an appropriate time for a break, Chair. 14:40

CHAIRPERSON: How long do you think you have got left to go?

MS. KILEY: I think an hour conservatively.

CHAIRPERSON: Okay. We will take 15 minutes and then start again. Can we try and start on time at five-to. 14:41

SHORT ADJOURNMENT

THE HEARING RESUMED AFTER THE SHORT ADJOURNMENT, AS FOLLOWS: 14:55

224 Q. MS. KILEY: Thank you, Mr. Whittle. So the next topic in Module 3 is 3D, "Safeguarding Policies". You deal with this at paragraphs 9.1 to 9.26 of your statement. 14:56

Now, in those paragraphs you chart the history of regional safeguarding policies and, as you know, the Panel has already heard from the Department about those because it's the Department that's responsible for the

regional safeguarding policies, isn't that right?

A. That's correct.

225 Q. So I won't ask you to repeat that. But there are some Bodies which you refer to within your statement in this area that HSCB did have a role in, so I want to ask you a little bit about those. 14:57

Firstly, at paragraph 9.6 you refer to the Department in 2002 setting-up a Regional Adult Protection Forum to promote, develop and improve arrangements for the protection of vulnerable adults. I just wanted to ask you whether the Board did in fact have a role on that Body? 14:57

A. Yes, the Regional Forum was established and shared by the Health and Social Services Board, the purpose being to - well three purposes: Firstly to promote awareness of adult protection, secondly to develop adult protection procedures, and thirdly to develop training. 14:57

The membership was drawn from the Health and Social Services Boards, the Health and Social Services trusts, the police and the voluntary sector, for example, Women's Aid or Help the Aged and it was in place until 2008. And it's products that it developed were threefold: Firstly, the Protocol for Joint Investigation of Abuse 2003, it supported the development of the No Secrets Guidance and the Joint Training Programme for the Joint Protocol, the assessment and investigation between the police and 14:58 14:58

Health and Social Services trusts, and minutes of meetings are available.

226 Q. Are you aware of how often it met?

A. I don't have the detail in front of me, but it was regularly through that period, certainly at stages monthly and other stages less frequently as it progressed it's work. 14:59

227 Q. You mentioned that it was in existence since 2008, what happened in 2008?

A. It was superceded by the Northern Ireland Adult Safeguarding Partnership NIASP. 14:59

228 Q. Yes, I want to ask you about that. You refer to this at paragraph 9.8 of your statement and, in fact, at that paragraph, Mr. Whittle, you refer to 2010 Joint Guidance Document entitled "Adult Safeguarding Northern Ireland Regional and Local Partnership Arrangements" and you say this guidance established the Northern Ireland Adult Safeguarding Partnership. So is it right then that it was 2010 that it replaced the Regional Adult Protection Forum? 15:00

A. Yes.

229 Q. Okay. You go on to explain, you say, the guidance established in Northern Ireland Adult Safeguarding Partnership, NIASP and five Local Adult Safeguarding Partnerships, LASPs. You say: 15:00

"NIASP was chaired by HSCB with memberships from Trusts, other statutory services such as Housing and Police, with membership drawn also from the community,

voluntary sector and faith groups. LASPs operated at Trust level configured along the same lines as the regional NIASP organisation and related back to NIASP in terms of their work."

15:01

You have also exhibited there the Regional Guidance, the roles of those Bodies are explained in more detail in that guidance. I would like to turn it up please, if we could have page 8271? If we could just scroll out to see that whole page please. So the role of the NIASP is set out there commencing at page 8271 and you can see that there are a number of responsibilities listed. The Panel has that information, I don't want to go through it all and ask you to repeat it.

15:01

15:01

If we could scroll down please to page eight, just to the next page I think please at (I). You will see that one of the roles is:

"To monitor and evaluate on a regular and continuing basis how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working."

15:02

15:02

Are you able to explain any more about how the NIASP did that in practice?

A. Unfortunately I'm not, other than the information that I have put in the written statement.

230 Q. Okay. And when you say NIASP was chaired by HSCB, what

were the internal reporting mechanisms, so how would the NIASP report back to the Board?

A. So, the Northern Ireland Adult Safeguarding Partnership was chaired by an Assistant Director within the Health and Social Care Board, a Mr. Keenan. Mr. Keenan would have reported to the then Director of Children and Social Care, a Mrs. McAndrews. The NIASP produced an annual report and that annual report would have been tabled at the Health and Social Care Board's Board meeting, so there was a formal reporting structure, there was a line management arrangement but also through to the Board's Board. 15:03 15:03

231 Q. In terms of that annual report, you say at paragraph 9.9 that the NIASP received data returns from The Trusts and analysed those. Are you able to assist the Panel with the type of data that the NIASP received from Trusts? 15:03

A. Only at a high level, but certainly can provide the detail in terms of what was requested subsequently, but it would be information such as the numbers of reported allegations, the number of investigations that were undertaken, the timeliness of those investigations, that would be the nature of the information that was collected. But, if helpful, I can provide the information the data returns that were submitted. 15:04 15:04

232 Q. Thinking about the role of the Local Adult Safeguarding Partnerships then, are you able to explain about how they fed back to the NIASP and, therefore, to the Board onward?

A. So if we, if you wouldn't mind if we pulled up page 8287?

233 Q. Yes.

A. And it will set out the role and responsibility of the local partnerships. So, again, you'll see a long list of roles there for the Local Adult Safeguarding Partnerships to work with the NIASP on the strategic plan to contribute to the delivery of an annual work plan for each of the locality areas, so that would be coterminous with each of the five Health and Social Care Community Trusts to implement guidance and operational policies and procedures in partnership with NIASP to measure how and to what degree the objectives, performance indicators and outcome measures set by NIASP have improved the quality. 15:05

And that is the information I will provide to the Inquiry to monitor and evaluate how well local services worked together and to encourage and develop good working relationships between different services, and ensure partnership organisations has a clear well-publicised policy of zero tolerance of neglect, exploitation or abuse and, lastly, to ensure strong effective links with other partnership such as Merrick or Propanie (phonetics). 15:06

234 Q. You said in your statement that the LIASPs operated at Trust level. We can see in the portion that you have just referred to that it said the role of the LIASP is located within each of The Trust areas who sat on the

LIASPs, were there Board representatives on those?

A. No, the LIAPS were chaired by the Health and Social Care Trusts and would have had a similar membership to the Northern Ireland Adult Safeguarding Partnership but at a local level. So it would have had police, Trusts, 15:06 faith groups, community voluntary sector, but would have been a local representation of those.

235 Q. At paragraph 9.17 you explain that the NIASP was stood down in 2020. I want to ask you about what you say about that. You say at 9.17, this is page 69. You 15:07 say:

"NIASP, which was chaired by HSCB through its regular meetings with Trusts was in a position to monitor practice and identify and access issues with respect to 15:07 the rollout and clearance regarding new practice, standards and procedures. NIASP was stood down in 2020 by the Department in recognition that stronger accountability arrangements were required. Consequently, the Department mandated the HSCB to 15:07 establish an Interim Adult Protection Board."

Are you able to elaborate any more on that statement that there was a recognition that stronger accountability arrangements were required? 15:08

A. Again, only in general terms because clearly that would not have been a decision of the Health and Social Care Board. However, I am aware that NIASP was stood down following concerns that had been expressed in relation

to the protection arrangements both in Muckamore Abbey Hospital, but also in Dunmurry Manor Nursing Home.

Certainly, there would have been discussion that I would have had with the Chief Social Services officer at the time with regard to, in spite of the arrangements being in place, that there wasn't as great a focus on protection as there should have been, which is why the Department were keen to move away from a safeguarding, broader safeguarding partnership, to an Interim Adult Protection Board which had a focus on protection. 15:08 15:08

That said, and I know that Mr. McGuicken has given evidence in this regard, there was also an intention to bring forward legislation with regard to safeguarding and adult protection and within that legislation an intention subject to the will of the assembly to bring forward an Adult Protection Board on a statutory footing and it is my understanding that the Department were keen that the Health and Social Care Board would establish an Interim Adult Protection Board to test that prior to the legislation being developed. 15:09 15:09

236 Q. Can you tell the Panel more about the Interim Adult Protection Board, who sits on it and what is it's remit? 15:09

A. The Interim Adult Protection Board comprises of each of the five, it's actually very similar membership in many regards to the NIASP in that it has the five Trusts,

and the police, alongside the RQIA, and the Patient Client Council, however, it doesn't have the same membership with regard to the faith sector and the voluntary and community sector. Those sectors would be represented on the local groups and part of that was the intention to ensure that the Interim Adult Protection Board had a particular focus on the statutory function, or rather, the statutory obligations pending the legislation on adult protection.

So it established a number of Interim Adult Protection Boards, it established a number of Working Groups, one on performance and data, one on training and development, one on procedures, particularly the refreshing of the joint protocol between the police and the HSC. One on user involvement and finally on serious case review and how those could be brought in to Northern Ireland.

237 Q. And you refer to the evidence which is the Inquiry has heard about, the proposed legislation, that is the Adult Protection Bill, is that right?

A. Yes.

238 Q. The Health and Social Care Board, as the Commissioner of Services and now the SPGG as Commissioner, did it submit, did either of those Bodies submit a consultation response to the draft legislation?

A. So the Department of Health's strategic Planning Performance Group wouldn't submit a response to a

consultation, because effectively the Department is consulting, so as a member of the Department we would have done our work in advance, and the way in which that would happen would be that the Department of Health Strategic Planning and Performance Group would be represented on the Transformation Board that was overseeing the Bill development, and I understand that Mr. McGuicken would have given evidence in this regard and the Transmission Board is considering the workforce, the training, the cost of implementation, issues with regard to the registration of the workforce and their training and the Bill itself, so that the Strategic Planning Performance Group would be part of the Board that was overseeing the development of the Bill. So it would be counterintuitive for the Bill Team then to consult with the people that actually designed it. 15:12 15:13 15:13

239 Q. So you are saying that it had earlier input essentially?

A. Yes. 15:13

240 Q. Moving on then to the next module which is 3E, "Policies and Procedures in relation to Medication and the Auditing of Medication". You deal with this at paragraph 10.1 onward of your statement. I think, in summary, you explain the Board's role and it fair for me to summarise the position as this: That the Health and Social Care Board don't set policy and procedure in the area and consider that the monitoring of compliance is a matter for the Department. Is that an accurate 15:14

summary?

A. Could I ask you to break the two parts of the question?

241 Q. Yes. So you have said that, and feel free to tell me if this is not an accurate summary, but you have provided a great deal of context in these paragraphs and what I am asking you is: Is it an accurate summary to say that the Board don't set policy and procedure in this area? 15:14

A. That's correct.

242 Q. And then in terms of monitoring and compliance, the Board consider that that is a matter for the Department of Health, is that right? 15:14

A. The Board has some responsibilities with regard to monitoring and compliance, particularly with regard to primary care and general practice. 15:15

243 Q. Okay.

A. We also monitor some specialist medications, the high costs which would have monitoring arrangements in relation to those.

244 Q. Yes, and I think you refer particularly to obligations of the Board under Misuse of Drugs legislation, you deal with that at paragraph 10.10 of your statement. 15:15

A. Yes.

245 Q. You refer to the Board being a Designated Body who, under the Misuse of Drugs legislation is required to nominate or to appoint a fit, proper, and suitably experienced person as an accountable officer? 15:15

A. Yes.

246 Q. Are you able to tell the Panel who the Designated

Officers in the Board are or were?

A. That's a very obvious question and one to which I should know the answer to but don't. Our Lead Pharmacist is Dr. Joe Brogan and whether he is the Accountable Officer I am afraid I don't know, but I will clarify and come back to the Board or come back to the Inquiry.

247 Q. Are you able to tell the Inquiry any more generally about how those Designated Officers would have exercised their functions in respect of Muckamore Abbey Hospital in particular? 15:16

A. I'm afraid I'm not. As I said at the start of the Inquiry, I am registered Social Worker by profession. This section is quite detailed with regard to pharmacy arrangements and has largely been prepared for me by the Pharmacy Team within the Health and Social Care Board. So I am very content that I have assured myself through the relevant direct information presented to the Inquiry is accurate, but if there are specific or technical details I would ask that I have the opportunity to refer those back to the Pharmacy Team who would have a higher level of confidence in this area than I would. 15:16 15:17

248 Q. DR. MAXWELL: Can I ask a question there, so some of the issues we've heard in the Inquiry are about the administrations of medicines and not controlled medicines. Is there any way, so you are talking on page 75.10.16 about controlled assurance processes, is there anything in the Pharmacy Controls Assurance 15:17

processes that would monitor the administration of medicines rather than the prescription and dispensing of them?

A. Sorry, would you just repeat the last part of the question again please. 15:17

DR. MAXWELL: So in terms of medicines, there are a number of different stages, so it will be prescribed by a registered prescriber, it will be dispensed by a pharmacist, and it will be administered by a number of different people. I think one of the things we are 15:18 interested in is how there is some control of the administration of medicines, which is what happens at the ward level.

A. Okay.

DR. MAXWELL: I am just wondering whether it comes 15:18 under the Pharmacy Controls Assurance Standards. I recognise that this isn't your area and you may not be able to answer that, but whether that is something...

A. I am afraid.

DR. MAXWELL: ...that your colleagues could answer. 15:18

A. Yes, I am afraid I wouldn't be able to answer that off the top of my head, but I am more than happy to get that information for the Inquiry.

DR. MAXWELL: Thank you.

MS. KILEY: We will move on, Mr. Whittle, to the next 15:18 topic which is 3F "Policies and Procedure Concerning Patient Property and Finances". That takes us to paragraph 11.2 of your statement, which is page 81. I just want to read an extract from that. You say:

"In the period 1999 to 2009, the HSSBs did not have a direct role in the management of patient's property and finances within a hospital setting. Instead, this was the responsibility of the HSS Trust or HSC Trust providing the care."

At 11.3 you say:

"This remained the case from 2009 in that the HSCB did not have a direct role in the management of patient's property and finances within a hospital setting." 15:19

We've referred earlier to the Board's role in quality improvement. How does that fit in to the policies regarding patient property and finances? So does the Board essentially monitor whether Trusts comply with those policies. Does the Board do that as part of it's improvement function? 15:19

A. I've checked this, the detail of this on a number of occasions with our Director of Finance within the Department of Strategic Planning and Performance Group. I'm not aware and I do not believe that we have a direct role in this regard, and that is certainly the advice that I have been given by our Director of Finance with the processes that I have described in the earlier arrangements. 15:20

If there were a difficulty that emerged with regard to

patient property or finances through a complaint, or a series adverse incident, or an early alert, we would become aware of it and we would address it. Beyond those processes we do not have a direct role in the oversight of patient property or finances.

249 Q. Okay. Moving on then to Module 3G and that is "Policies and Procedures Relating to Psychological Treatments Speech and Language Therapy, Occupational Therapy and Physiotherapy". You deal with that at paragraph 12.1 onwards. 15:21

Again, you say the day-to-day operational procedures were a matter for The Trusts in that area. But you do say at paragraph 12.4 that the Board had a role in performance management of Trusts in response to waiting list targets regarding the provision of non-in-patient psychological therapy. 15:21

So, the Board was receiving data on non-in-patient psychological treatment, but what was the position about in-patient treatment, did it receive any data about that? 15:22

A. No. This was performance management and information that was being required as consequence of a particular commissioning plan direction that there would be targets in place with regard to non-in-patient psychological services and it is referenced in this section of Module 3G purely because it relates to psychology. But in reality, it is just part of our 15:22

ongoing management of performance with regard to targets or indicators of improvement.

250 Q. Yes. So is it right then to say that in respect of Muckamore Abbey Hospital as an in-patient facility, the Board did not receive information about the number of patients who were referred to psychologists? 15:22

A. Yes, that's correct, and the performance management arrangements with regard to Muckamore were largely related to targets with regards to re-settlement or timely discharge. 15:23

251 Q. And you've mentioned re-settlement there which I want to ask you about now. You deal with this at paragraph 13.1 one onwards of your statement. Again, you say that:

15:23

"The role of setting policy for re-settlement was a matter for the Department."

But at paragraph 13.3 you confirm that:

15:23

"The role of the Boards was in outworking of the re-settlement policy."

So I just want to refer you to that paragraph 13.3, you say: 15:23

"All legacy HSSBs had responsibility for patients whose home post-code was within their geographical boundary. With respect to re-settlement, this responsibility

included planning, monitoring, and evaluation of re-settlement progress. This responsibility passed to the Regional HSCB when it was established."

You then at paragraph 13.7 set out the re-settlement mechanisms in the period between 1999 and 2007and I think you explain that there were some difficulties in providing information because the records held are only partial, is that right? 15:24

A. That's correct, sorry to cut across, Ms. Kiley. If I might just go back to 15.3? 15:24

252 Q. Yes?

A. So I had referenced all Legacy Health and Social Services Boards had responsibility for patients whose home post-code was in the geographical boundary. In preparation for my evidence, as I reviewed my statement again, reflected on that paragraph, I think that would actually more accurately, would have read: All Legacy Health and Social Services Boards and Health and Social Services Trusts had responsibility for patients in the post-code, I think it is a shared responsibility of the Commissioner and the provider and, likewise, in the final statement: 15:24 15:25

"This responsibility passed to the Regional Health and Social Care Board when it...". 15:25

I think that would better read: This responsibility passed to the Regional Board and the Health and Social

Care Trust.

253 Q. Yes. In terms of the joint responsibility, both in the Legacy Board and in the Regional Health and Social Care Board, were there any policies that existed to guide the relationship between those two parties, the Board and The Trust? 15:25

A. No, I don't believe there was.

254 Q. I had taken you to paragraph 13.7 and the caveat that some of the records between 1999 and 2007 are only partial. But, you do say at the end of paragraph 13.7 that: 15:26

"Those records held by SPPG confirm that EHSSB issued letters to Trusts regarding the redevelopment and commissioning of MAH during 2004 to 2007 and arrangements were put in place to monitor the number of discharges and admissions. These arrangements appear to have involved receiving and reviewing monthly returns regarding admissions to and discharges from MAH and seeking updates from Trusts; why, for example, discharge was delayed." 15:26 15:26

You have provided a number of exhibits that are available to SPPG in respect of this period. I want to look at some of those please. If we could turn firstly to page 9988. So you can see there, Mr. Whittle, this is a letter from the Assistant Director of Social Services to the Business Manager in the North and West Belfast Trust and it's dated the 20th of September 15:26

2004. You can see there that it is a response to a letter from The Trust it seems dated 6th August. The response says:

"Further to your letter of 6th August, requesting a funding contribution to the above initiative, I regret to inform you that the Board is not currently in a position to do so. We are attempting to address a number of significant non-recurrent funding submissions at present, including some from North and West Belfast Trust. We will, however, keep your request under review in the event of any resources becoming available." 15:27 15:28 15:28

I should also have read the title in bold there in the middle is "The Service Improvement Project: Improved Discharge Process is Muckamore Abbey Hospital. So it seems here that this is a letter from the Board going back to the Trust refusing a request for funding contribution for improved discharge processes for Muckamore Abbey Hospital, is that right? 15:28 15:28

A. Yes.

255 Q. Are you able to explain anything to the Panel anything more about that letter and it's context?

A. No, unfortunately I'm not. This is a number of exhibits which I put in place to show the communication that went back and forth. I am aware that with regard to funding that that was not one of the modules that I would be giving evidence on, but I am also aware that 15:28

my colleague, Mr. McGuicken, is doing a supplementary statement and I believe that's going to reference funding over the period of the time, so that might be a more appropriate place to address the issue of the funding and investment. With the specifics of the letter, other than it shows that there was correspondence to and fro the context behind that I don't have.

256 Q. Yeah, but just in terms of funding there, and you say the Department is going to address this, here it seems that there was a request for additional funding made of the Board. So is it the Board's role to prioritise funding, even though the Department gives the funding, does the Board have a role in prioritising it, for example, to meet re-settlement? 15:29

A. The Board will receive, sorry, I beg your pardon, the Board received money from the Department for specific intentions and it would have to be utilised in that regard. At times, over the course of any given year, there may be additional funding which could become available, for example, through monitoring rounds where Government Departments have additional finances available because projects haven't been delivered in other Departments and that can be re-allocated. 15:30

The Health and Social Care Board would historically have liaised closely with the Department with regard to monitoring rounds so that if there were cost pressures that were before a Trust and they are able to meet that

cost pressure they would do so. So, whilst on the one hand the Health and Social Care Board simply receives the money from Government, commissioned services to deliver the intention and executes that, separately it is not unusual for a Health and Social Care Trust to raise a cost pressure. And if the Health and Social Care Board can assist with meeting that cost pressure with additional resources that would have become available it would have done so previously. So in general terms, I can understand why there might, or where there is a letter, the detail behind it I just simply do not have today. 15:31 15:31

257 Q. Okay. In this section then you move on at paragraph 13.8 to explain the establishment of a Regional Re-Settlement Group in 2007. You provide its Terms of Reference, there is no need for us to turn to them, the Panel has them. This was, as you say, to be chaired by the Department and you say that the Terms of Reference, I am reading from paragraph 13.9 now of your statement. This is page 84. You say, quoting from the Terms of Reference: 15:31 15:32

"This group to be established to oversee the discharge of patients across the three learning disability hospitals, Muckamore Abbey Hospital, Longstone and Lakeview." 15:32

You say that no records were found to establish if that Group was formally constituted. If it didn't meet,

what was the regional oversight of the re-settlement process at that time?

A. My understanding was that this was the Regional Oversight but, unfortunately, and I wish that I could, I can't identify the Team, have not been able to identify the records to support that, but I am not aware of any other vehicle that would have been placed other than this Group.

258 Q. And did the Board have a role on this group?

A. The only detail that I have available to me is that which I provided to the Inquiry in terms of the Terms of Reference. 15:33

259 Q. But is it the Board's understanding that the Group did actually meet?

A. Well, I can only refer to the records that I have before me. So my understanding is that it did, but I am speculating, if I haven't got the records. 15:33

260 Q. And the SPGG doesn't hold any records of any meetings of that Group?

A. No. 15:33

261 Q. You do then refer at paragraph 13.12 to a Community Integration Project. This, you say, from 2012:

"Meetings were held to consider the re-settlement agenda and these were chaired by HSCB Senior Managers, for example, the performance, finance and social care leads and assistant director for social care." 15:34

Can you explain anything more to the Panel about the

Community Integration Project?

A. The Community Integration Project has been going on in one shape or form from 2012 to date. So it has continued for this last decade overseeing the re-settlement of individuals from Muckamore Abbey Hospital to the community. The meetings were initially chaired by the Health and Social Care Board and then subsequently by the Belfast Trust and then there is details there on my paragraph 1314, bringing it up-to-date with regard to, they were reconfigured in 2021 and '22 to increase the focus on the progress of re-settlement and to, again, be chaired by Health and Social Care Board and updated Terms of Reference for the Community Integrated Project as set out on my exhibit on BW175. 15:34 15:35 15:35

262 Q. And you have provided in fact a number of sample minutes of the meetings related to that project. I don't think we need turn to them but, is it one of the ways in which the Board monitored the progress of re-settlement over that period? 15:36

A. The monitoring would have been undertaken through the performance meeting that we referred to earlier. I would have considered this to be one of the ways in which the Board worked with its Health and Social Care Trusts to execute the re-settlement arrangements. So that would have been by way of working through those people who needed to be re-settled, what alternative community provision could be put in place and working with Trusts to establish those. So it was more of a 15:36

delivery group than a monitoring group.

263 Q. And was the project looking at individual patients then?

A. Yes, it would have gone to individual patient level.

264 Q. The next group that you refer to is the Regional Learning Disability Operational Delivery Group. You refer to this at paragraph 13.15 and it was established in 2019. You say that: 15:36

"The establishment was to meet monthly to further advance re-settlement in accordance with the Muckamore Abbey action plan." 15:37

Can you explain any more to the Panel about why that group was set up at that particular time? 15:37

A. The rationale for why it was set up by MDAG I am not aware of. What I can explain to the Panel is that this was a broader membership than the Community Integration Project. There was also a broader task in terms of - broader terms of reference than the Community Integration Group. It was established by the Muckamore Cross-Departmental Assurance Group to monitor the effectiveness of health and social care systems and actions in relation to Muckamore Abbey Hospital. 15:37 15:38

So it was broader than just re-settlement, whereas the Community Integration Project had a re-settlement focus, albeit the Regional Learning Disability Operational Group also considered re-settlement, so it

was being considered in two different venues.

265 Q. And did this Regional Group look at it at that individual level that the Community Integration Project did?

A. It did that on an individual level and also, if you see my paragraph 13.16: 15:38

"The purpose and objectives were to provide the Department with assurances regarding the health and social care action regarding governance following the 15:39 Way to Go Review into safeguarding at Muckamore Abbey...".

And to provide oversight regarding the then Permanent Secretary's commitment on re-settlement made in 2018 15:39 which is why it has one part of it with regard to re-settlement and the other part is with regard to the "way to go" recommendations, which provides broader in establishing the Regional Learning Disability Operational Delivery Group. It ran concurrently with 15:39 the Community Integration Project rather than replacing it.

266 Q. Okay. Finally, in respect of re-settlement, at paragraph 13.18 you refer to the recommendations of the Independent Review of the Re-Settlement Programme 2021 15:39 to 2022. Now, this was a Review commissioned by the Health and Social Care Board in October 2021, isn't that right?

A. Yes.

267 Q. And it was an independent review on the Learning Disability Re-Settlement Programme in Northern Ireland with a particular focus on Muckamore Abbey Hospital. You have provided the document, it's at page 10066. It's there for the Panel, I don't intend to go through the review and recommendations in detail. But, and indeed this Panel will come to it's own views on the re-settlement process, but it's fair to say that it is clear that the Board missed re-settlement targets, would you accept that, Mr. Whittle? 15:40

A. I think it's clear to all that re-settlement targets established by Government were not delivered on in the time that they were intended to be delivered on.

268 Q. Can you elaborate any more for the Panel on the particular challenges that led to that situation? 15:41

A. In terms of why re-settlement targets were missed?

269 Q. Yes?

A. I haven't prepared that for my evidence today. In terms of the preparation for the evidence, I've tried to set out the processes, the arrangements, the structures that were place, but I have held back from commenting the effectiveness or efficiency of those processes. I think for today I should just stop by saying that it didn't deliver the aspiration or the intention behind the targets. 15:41

270 Q. Yes, okay. If we move on then to the next topic which is whistle-blowing, you address this at paragraph 14.2. Again, I am summarising, but you can tell me if this is fair, Mr. Whittle, but is it right to say the HSCB

position was that whistle-blowing policies in relation to concerns at Muckamore was a matter for The Trust, is that right?

A. Yes, whistle-blowing policies relate to each individual organisation and whilst the Health and Social Care Board would have had a whistle-blowing policy, I wouldn't have anticipated that staff in Muckamore would have gone to the Board's policy, they would have done that through their own organisation. 15:42

271 Q. In that case I just have one question about the Board's role, so if a member of Trust staff did whistle-blow under the Trust's whistle-blowing policies, how would the Board have known about that? 15:42

A. The Board would not know about that unless it was reported to the Board by way of a serious adverse incident under the Scheme of Delegated Statutory Functions, or we became aware through being copied into an early alert, so we would not routinely know unless it came up through one of our quality management processes. 15:42 15:43

272 Q. Okay. Moving on to the next topic then, 3J, which you address at paragraph 15.1 onwards. This is "Overview of Mechanisms For Identifying and Responding to Concerns", and I think you have just touched on that because in this section, again you refer to the processes that you gave evidence about earlier. So for example, the early alerts, SAIs and complaints. Is it right then that the HSCB's position is that the mechanisms by which it identifies and responds to 15:43

concerns are those eight processes which you have already set out to the Panel?

A. For the Health and Social Care Board it would only be for seven of them because one of them relates to Legacy Adverse Incident Reporting, which would have been an Eastern Board process, so it would be seven for the Health and Social Care Board, eight for the Legacy Boards.

273 Q. Okay. The next topic then is 3K, "Risk Arrangements and Planning Regarding Changes of Policy". Now, you deal with this at 16.1 to 16.6 of your statement. I want to ask you about the Risk Registers which you refer to in this section, Mr. Whittle. In relation to Legacy HSSB, you say at paragraph 16.3 that they had a Risk Register but that searches are ongoing for Legacy Risk Management Policies in the HSSB. I just wondered if any progressed been made on those searches? 15:44 15:44 15:45 15:45

A. I am afraid I don't have the detail of that before me today, but I will certainly clarify.

274 Q. And as for the position then with the single Health and Social Care Board, you say at paragraph 16.4, you make reference to the Governance Framework that was introduced in 2011 and you refer in that respect to the "management of Board-wide risks". I don't think we need to turn to that document in particular, but is it right to say that the Board's arrangement was this, there was a Corporate Risk Register and Directorate level Risk Register, is that right? 15:45 15:45

A. Yes, that's correct.

275 Q. Can you explain to the Panel who decided what was noted firstly, on a Directorate level Risk Register?

A. The Directorate Register, a risk assessment would be undertaken by Directorate team members. They would be referred to a relevant director who would make a call then with regard to whether those would be held at director level, or whether those would be remitted to the Corporate Risk Register. There would be a discussion between each of the directors around the senior management team with regard to the Corporate Risk Register and which risk would be held at a corporate level. 15:46 15:46

276 Q. In terms of that discussion and the decision about whether a risk should be held at Directorate level or corporate level, was there any guidance given to those individuals as to the type of risk that constituted a Directorate level or a corporate level? 15:46

A. I'm going to ask the Panel, with your agreement, if I could clarify that. I believe there was but I don't want to give erroneous evidence. Might I just say something with regard to the issue of risk assessments regarding planned changes of policy more generally? 15:47

277 Q. Yes.

A. As we've said in previous evidence, the Health and Social Care Board was not responsible for policy change, where a policy change indicated a risk it would be unlikely, in my experience, that that would be picked up through the Directorate or the Corporate Risk Registers. I think so, if you have a policy which has 15:47

been implemented, Bamford or Equal Lives, that there would be a risk assessment of the policy because the expectation would be the policy would be implemented through our usual commissioning arrangements.

15:48

However, as that policy or any policy is implemented then risks or issues could emerge over the course of time and those could be across any number of issues. It could be financial, it could be staffing, it could be the speed or pace of implementation, and it is those 15:48 issues with regard to the ongoing implementation that are more likely to be picked up through the corporate and Directorate risk arrangements that I have set out in my evidence there. So hopefully that will assist in terms of how we would use this process as a result of 15:48 policy.

278 Q. DR. MAXWELL: Can I just ask, so one of the risks that presumably you're looking at is business continuity, and so if there are unintended consequences that risk the business continuity, how would that be identified? 15:49

A. So that would be - if there was a particular issue with regard to business continuity that would come up through the staff within the Health and Social Care Board identifying the issue through their contact with the Trusts and that would be; a risk analysis would be 15:49 undertaken. That could be held in the example of Muckamore Abbey, there could be risks which were held at either Directorate level within the Health and Social Care Board, or at a corporate level, and indeed,

at different times there have been risks registered at both corporate and Directorate level with regard to Muckamore Abbey Hospital. And again, I forget whether these have already been shared with the Inquiry, but if they haven't, then I will ensure that they are. 15:49

279 Q. DR. MAXWELL: Would you rely on, in this case, the Belfast Trust to alert you to the fact that there was a risk to business continuity?

A. Yes, essentially, and Dr. Maxwell, this goes back to how does the Health and Social Care Board know that 15:50 something is working or not working in the way that one would want it to work, and as I have set out in earlier evidence, we have a limited suite of arrangements in place, historically it is to do with the seven that we referred to. So if they come up through that process 15:50 we would be aware that there were particular difficulties or risks which would be assessed and can then be held on the Risk Register. If they go onto the Risk Register then mitigations will be considered, how you would mitigate against any particular risk at a 15:50 point in time.

280 Q. DR. MAXWELL: So we've heard a lot of evidence that staffing has been a challenge, particularly in latter years but for quite a long time. At one point who would make the decision that that is a business 15:50 continuity risk?

A. Ultimately that would be down to the risk assessment of the - it would be highly unusual for the Health and Social Care Board staffer not to know of an issue with

regard to staffing, just of the close working relationship that the Board had with its Legacy Trusts and that would be something which it would consider as part of the routine review of the risk. Risk assessments and review of the Risk Register which is done on an ongoing business, both formally, in terms of there are set points during the year were directors would be asked to consider new or emerging risks, but also any member of the team can raise a risk at any point with a director and ask that there is a risk assessment undertaken. 15:51 15:51

DR. MAXWELL: Thank you.

MS. KILEY: Thank you, Mr. Whittle. I am going to move on to the next module topic which is 3L "Procedures to Provide Assurance Regarding Adherence to Policies". You address this at paragraph 17.1 onwards. At paragraph 17.3 you refer to the structures which you described earlier in your statement. 15:51

So, is it the case that the processes, the seven processes for the Health and Social Care Board and eight for the Legacy Board are again the ways in which the Board provided assurance regarding adherence to policies? 15:52

A. Yes. 15:52

281 Q. I have already asked you some questions as we have gone through the various topics about specific arrangements for monitoring. So I have no further questions on that topic.

The final module topic then is 3M "Policies and Procedures for Further Staff Training and Continuing Professional Development". Now, you deal with this at paragraphs 18.1 to 18.19 of your statement. You refer to the internal training which the Health and Social Care Board provided, internal training which Health and Social Care Board provided to it's staff and then also training which the Board provided to Trust staff. It is the latter which I want to ask you about. 15:52 15:53

You refer to the Leadership Centre at paragraph 18.11 and you say that it had a dedicated remit for management and leadership development. Can you tell the Panel a little more about that Body and how it furthered staff training and continuing professional development? 15:53

A. So the Leadership Centre is a unit of the Business Services Organisation. It is a training and organisational development function of the HSC which each of the Health and Social Care Organisations can access. So all Trusts, and indeed the Health and Social Care Board, would have a contractual agreement, a service level agreement for accessing the services of the Leadership Centre. So whilst - so any individual Trust could access the support for leadership development, or organisational change, or team development, but that would be a matter between any Trust and the Leadership Centre and the Health and 15:53 15:54

Social Care Board would not be cited on that.

That would be out with our monitoring arrangements that we would know the services, the Health and Social Care Board would get from the Leadership Centre, but we would not have oversight of the utilization of the Leadership Centre by other HSC organisations.

282 Q. Over and above that then, does the Board provide funding to Trusts to deliver their own training?

A. I've referred - Trusts with regard to their general staff training will organise their own training within their own resources, where I have made the distinction is with regard to social work and social care training which is on paragraphs 18.12 on page 104 of my statement following. The Health and Social Care Board makes available funding to Trusts in the order of £600 to one-million pounds per year depending on the particular needs and issues at the time with regard to the supporting their social work and social care workforce. 15:54 15:55 15:55 15:55

283 Q. And did the Board have a role in monitoring whether the training being put in place was suitable and adequate, and in referring there to the training being put in place by The Trusts which you have referred to?

A. Not with regard to the training as put in place by The Trust. 15:56

284 Q. So it had no mechanism by which to oversee that?

A. No.

285 Q. In terms of budgets for training we've touched on some

different areas there, but I want to ask you about the Chief Professional Officers in the Department of Health. Are you aware of whether they hold additional budgets for continuing professional development training? 15:56

A. I am not aware of the budgets which they hold.

286 Q. Would it be open to the former Board or to SPPG now to seek additional levels of budget from the Department to deliver specific areas of training or continuing professional development? 15:56

A. There has, certainly my experience of working in the Health and Social Care Board and within the SPPG, there have been a very close relationship between Board officers and policy colleagues in the Department and also professional officers, albeit for professional 15:57 officers, as a registered Social Worker, my line would be through to the office of the Chief Social Services officer. Routinely there would be discussions with regard to pressures and attempt to identify funds for commissioning an activity to be undertaken. So it 15:57 would be very common for there to be those sorts of conversations to influence the Department colleagues with regard to what funding might be available.

MS. KILEY: Okay. Mr. Whittle, you will be pleased to hear that those are all my questions on the various 15:57 topics that you have addressed in your statement. The Panel may have some additional questions for you.

END OF EXAMINATION OF MR. WHITTLE BY MS. KILEY

MR. WHITTLE, HAVING BEEN SWORN, WAS QUESTIONED BY THE PANEL, AS FOLLOWS:

CHAIRPERSON: I just wanted to come back to one issue which was safety quality alerts and you may not be able to assist me, but I just want to make sure I don't mislead myself from some limited knowledge of what happens in England, because those are I think often used in England for issues which arise, for instance, in relation to equipment, or medication packaging which looks very similar to another piece of medication, and an alert goes out. 15:57 15:58

So it's very often specific technical issues which arise which cause an alert to be sent out. Is it wider, used in a wider sense in Northern Ireland? 15:58

A. Chair, yes, it's wider.

CHAIRPERSON: It seems to be from what you told us, I want to understand. 15:58

A. Medicines, Regulations, equipment, device failures, those would all go out through safety and quality alerts, but so would learning from serious adverse incidents, or complaints, or the broader range of issues that are spoken about. 15:59

CHAIRPERSON: Those sort of themes that might come from SAIs might go out as a safety quality alert.

A. Yes.

CHAIRPERSON: Right, that's very helpful. Can I thank

you very much, because it's very obvious from the way that you've given evidence and your ability to cross-refer with great speed, that you've put in a huge amount of preparation to your evidence. You've also re-read Professor McConkey and Mr. McGuicken. So I understand how much preparation that must have taken, so can I thank you very much for spending the time to do that. 15:59

Also thanks to you, Ms. Kiley, because it has been a long day and a lot of preparation went into that. So thank you, Mr. Whittle, you can now go with the secretary to The Inquiry. I have just got a few words to say about next week. 15:59

16:00

END OF QUESTIONING OF MR. WHITTLE BY THE PANEL

(THE WITNESS WITHDREW)

CHAIRPERSON: As you know, we're sitting next week on Wednesday and Thursday. We hope to be able to publish the schedule of sittings to the end of June by the end of next week, and I'm sorry there is a bit of a delay about that. As you can imagine, there is a lot of work going on in the background to try and get witnesses organised. I can say that it is very likely that Module 6 will have to be parked until we sit again after the summer break for reasons that will eventually become clear. In the meantime, thank you everybody. 16:00 16:00

we'll sit again Wednesday next at 10 o'clock in the morning. Thank you.

THE HEARING ADJOURNED UNTIL WEDNESDAY, 24TH MAY 2023 AT 10:00 A.M. 16:00